the Canadian Nurse

VOLUME 60 • NUMBER 12

MONTREAL

DECEMBER 1964

Greetings for Christmas and the New Year

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Between Ourselves

When the competition for the design of a new cover for the *Journal* was announced in this column last summer, no one had even the remotest guess what kind of a reponse might be expected. With the closing date set for September 30, entries began to dribble in toward the end of August. No one anticipated the tremendous interest and enthusiasm with which subscribers or their friends in all parts of Canada, and even in the United States, rose to the challenge. Literally dozens and dozens of entries poured in.

As you may imagine, the judges who had been appointed by the Journal Board did not have an easy task when they assembled on October 14.

You will see the design that received the top award when the new format comes into being next month. It was produced by Mr. ANTONIN LACROIX of Montreal. The second prize went to Miss BENTE HEJLSTED of Winnipeg, from which city also Mr. PHILIP SUTER, third prize winner, sent in his entry.

To all competitors, our sincere thanks for making this one of the most exciting events in the *Journal's* sixty years of publication.

* * *

This last edition in the smaller format contains a miscellany of useful information that will suit almost everyone's taste. Leading off the editorial content is a Christmas message from our new French assistant editor, MARGUERITE MORIN. Well known to nursing leaders across Canada but particularly those in the four westerly provinces, Dr. S. R. LAYCOCK tackles a ticklish problem in nursing education — the teaching of nursing ethics.

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Read what Dr. JOHN DOSSETOR thinks about the responses of a gullible public to the promises of speedy relief from pain. Sure, there are occasions when phenacetin compounds have a role to play in treatment. But think hard about how much you or your friends, even your own child needs the self-medication before you take the stopper out of the bottle or you open that convenient little tin container in your handbag.

* * *

As one of the important national organizations that is deeply concerned with the hopes and aspirations of its members, the Canadian Nurses' Association presented its Brief to the Royal Commission on Biculturalism and Bilingualism earlier this year. As a ready reference for you, this Brief is reproduced in this issue.

* * *

The time has come to pack up issue number 12 of volume 60. While we at the *Journal* office look forward with considerable excitement to the preparation of the new sized book, there will be some complications.

We have a modest supply of the binders for this year's copies on hand. No more of the smaller size will be ordered so if you wish to secure binders for your 1964 or other earlier issues please do not delay. Send your cheque or money order to the Journal soon. Incidentally, the 1964 index which should be available by next February, will be printed in the same size pages as this issue.

* * *

Your entire editorial staff, the seven member team in the circulation department, the advertising manager, bookkeeper and all the rest of the staff join in wishing each of you who reads these lines a wonderful time in the rapidly approaching holiday season.

We will be looking forward to hearing from you when the new issues reach you in 1965.

HAPPY DAYS!

THE CANADIAN NURSE

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Indications—"Suvrinal" 400: 1. For anxiety and tension states, tension headache, insomnia, menstrual tension, muscle spasm, behavioral problems. 2. As adjunctive therapy in alcoholism, allergy, hypertension, gastrointestinal dysfunction, psychotherapy, rheumatic and related disorders, e.g. fibrositis, cerebral palsy, petit mal and related minor epileptic disorders; pre- and postoperative sedation, etc. 3. In vitamin deficiencies associated with 1 and 2 above.

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RESINOL OINTMENT AND SOAP

Random Comments

Dear Editor:

It is most gratifying to see that the CNA is willing to encourage more men to enter nursing. It is also gratifying to note that both the Royal Commission and Dr. Naegele (Sept. 1964 issue) recommend that nurses should put forth an organized effort to increase salaries in order to bring them into line with similar professions. However, it is high time that nurses, themselves, realize that if they want more male nurses in Canada the salaries must rise to allow men to support families. Until salaries are altered significantly, male nurses will remain as they are now — an almost insignificant minority.

DAVID W. ADAMS, REG.N., Ontario

Dear Editor:

Will you please publish the following announcement:

Attention all graduates of the Royal Victoria Hospital, Montreal, Class 1960 "B."

Plans are underway for our five-year reunion. Please send your name (single and married), as soon as possible to either Mrs. Jean (Stewart) Macintosh, 17 Ford St., Brockville, Ontario, or to the undersigned:

MRS. PAT (SCOTT) DUBREUIL,
780 Lakeshore Drive, Apt. 703,
Dorval, Quebec.

Dear Editor:

In June, 1965, St. Joseph's School of Nursing Alumnae Association, Guelph, Ontario, will be celebrating its Golden Anniversary.

We ask all members of the Alumnae Association to contact us, sending their correct address, maiden and married names, and year of graduation.

MRS. BEULAH STULL,
Corresponding Secretary.

Dear Editor:

I wish to tell you how much I enjoyed the article "Nursing Care in Obstetrics" by Francene McCarthy. The paragraph stating that the nurse should sit with the patient, talk to her and listen to her is *so* important!

I am a registered nurse, and before I had my first baby I attended the VON prenatal

classes. I thought that I was very well prepared, mentally, for labor. But when it happened to me, I was absolutely terrified. I can never adequately express my gratitude to the nurse who sat with me and held my hand and talked to me. It helped *so much.*

I have heard many women, nurses and non-nurses, complain that when they were in labor the nurse left them alone most of the time and just didn't seem to be concerned that they were afraid.

I know that case-rooms are usually busy areas and often under-staffed. Nurses should remember, however, that a kind word and a listening ear helps the patient in labor as much as the analgesic that is administered.

MRS. BARBARA O'BRIEN, Ont.

Dear Editor:

I miss the case studies that *The Canadian Nurse* used to publish. The trend of the magazine has strayed from what it once was. I find it very uninteresting and eagerly peruse any clinical studies should the odd one be included. I am a young graduate and I can already see a progressing departure from real bedside nursing, demonstrable in the changing form and policy of the *Journal.* It is good to report on the tea-party activities of our nurses and the association but a few of us enjoy a bit more food for thought which used to be afforded by the excellent case studies you no longer feel are a part of nursing.

JEANETTE FRUNCHAK, Alberta

¶ *Twenty-one nursing care studies have been published since January 1st this year, exclusive of those found in the cardiovascular and public health issues. It is true that we print fewer studies now than we did 15 years ago. Some readers complain that we should not publish as many as we do, since details concerning nursing care are available in a variety of textbooks.* Ed.

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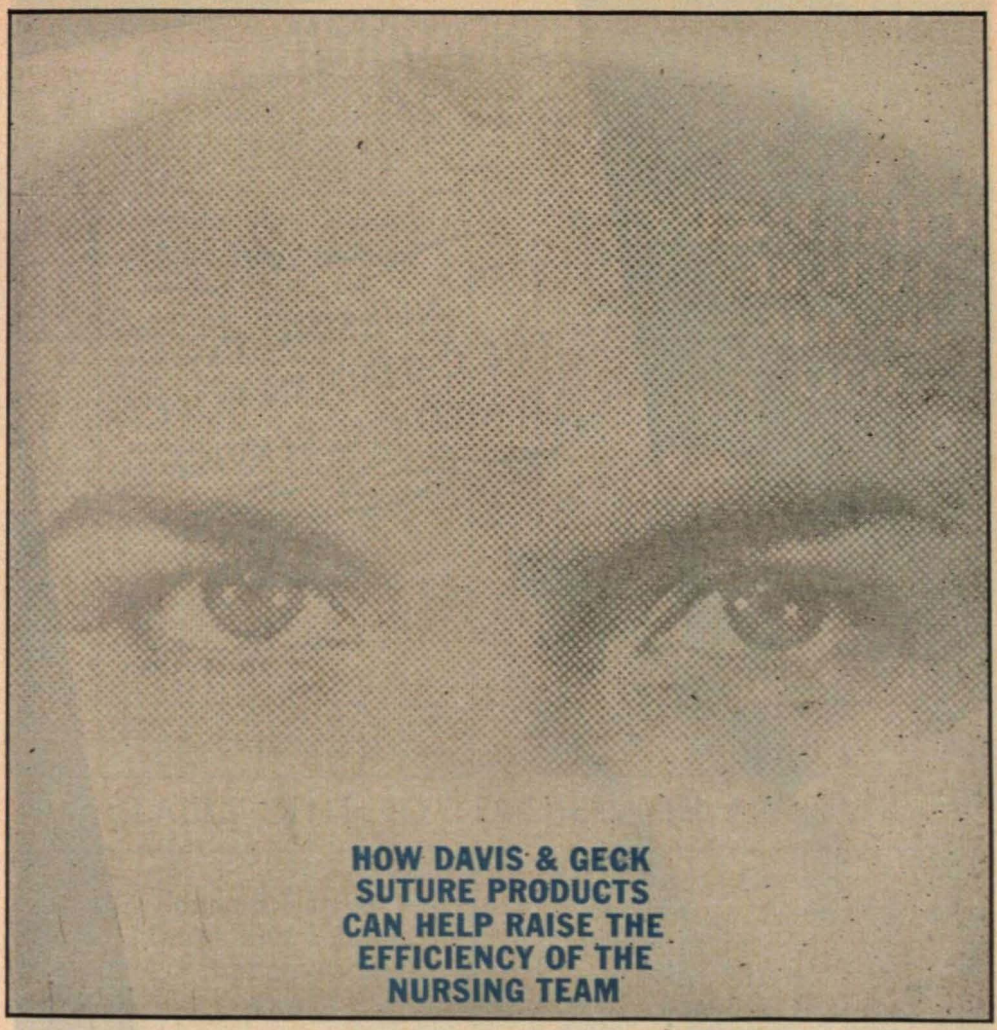

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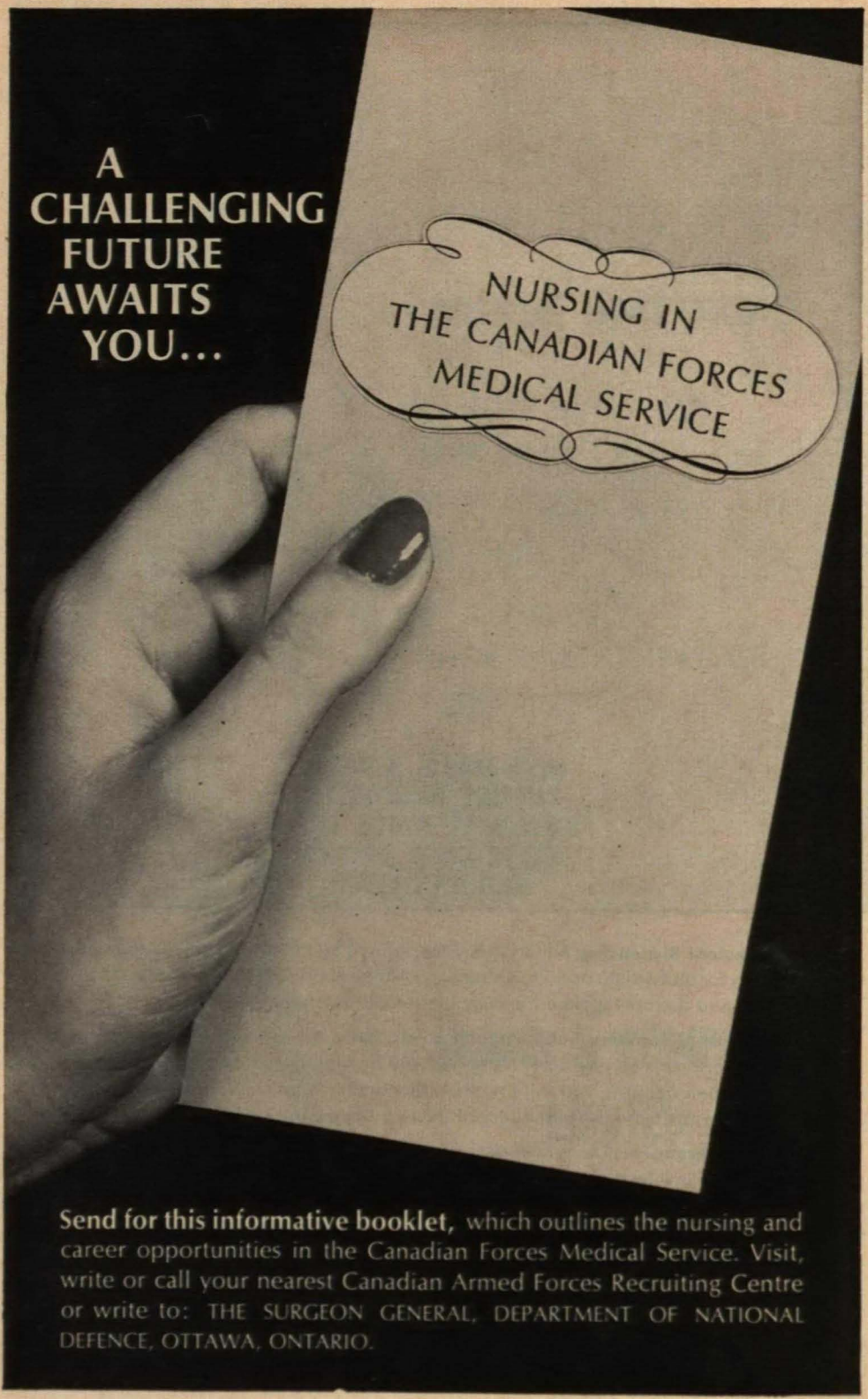
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By MARY C. ABDELLAH, R.N., formerly In-Service Director of Nursing, St. John's Hospital, Oxnard, California. 200 pages, 5¾" x 8", illustrated. About $3.25.

New—Ready in January!

Thompson — Pediatrics for Practical Nurses

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By ELEANOR DUMONT THOMPSON, R.N., formerly Pediatric Clinical Instructor, Practical Nurse Students, Mary Hitchcock Memorial Hospital, Hanover, N.H. 304 pages, 5¾" x 8", with 113 illustrations. About $4.60.

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Keane & Fletcher — Drugs and Solutions
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By CLAIRE B. KEANE, R.N., and SYBIL M. FLETCHER, R.N., both of the Athens General Hospital, Athens, Georgia. 192 pages, 5" x 7". About $3.25.

New—Ready in January!

Pelley — Nursing
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A skillful combination of nursing history and professional adjustments in one compact volume. Closely following Canadian nursing school curricula, the author leads the student to a fuller understanding of the trends through the ages which have shaped modern nursing practice. Development of nursing is traced from medieval Europe to the present. Practical discussions of the philosophy and ethics of nursing, help the student prepare for a nursing career by today's standards.

By THELMA PELLEY, R.N., Director of Nursing, Stratford General Hospital, Stratford, Ontario, Canada. 238 pages, 5½" x 7". $4.05.

New—Published August, 1964!

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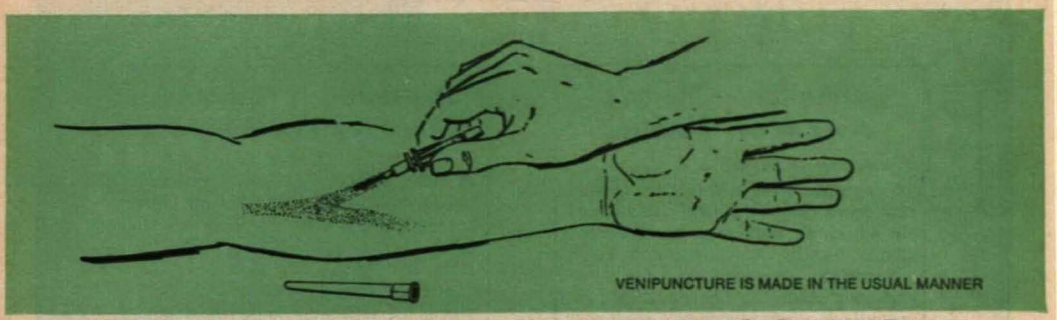

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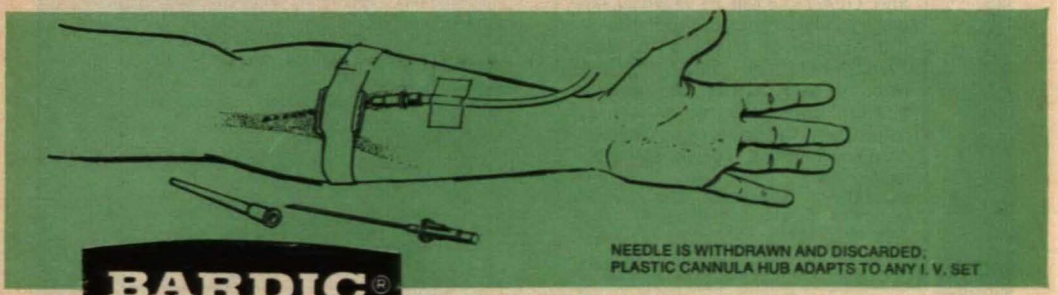

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Values in Daily Living

Everyone has a philosophy of life. Each being is motivated, consciously or unconsciously, by the way he thinks and the way he evaluates himself and his environment. His whole self is involved everywhere he goes, in everything he does. The key concept that gives the exact tone to one's philosophy of life is the *value-system*.

Value is a word of different meanings. It has several implications, depending on whether it is used by a philosopher, mathematician, economist, artist, politician or scientist. But the most important aspect of values lies in the role they play in daily behavior. They are strong dispositions, always ready to influence patterns of conduct; they act as a moral guide — that common sense or "rightness' or "wrongness' of a given action; they play a role in the choice of friends; they give direction to one's daily task. They strongly influence the individual within a nation — for instance, the Japanese people value perseverance and respect for old people; the British value self-discipline and traditionalism; Americans value the realization of the most modern techniques; Indians value asce-

MARGUERITE MORIN

tism; Russians value materialism; and French value intellectualism.[1]

Viktor Frankl, a Viennese neurologist, has suggested three categories of values that are accessible to all:

1. *Creative values:* Men can realize creative values by thinking, planning, working and performing. These may range from familiar, daily acts to the most subtle thinking of a philosopher or the elaborate planning of an engineer.

2. *Experiential values:* These can be realized by an appreciation of the beauty of nature, art, friendship, truth and goodness.

3. *Attitudinal values:* These involve the way a man faces his destiny from which he cannot escape but can only accept.

In other words, Frankl believes that these values should be an integral part of man's life. He stresses that happiness and well-being have no meaning by themselves, but are the consequences or effects of a realization of other values.[2]

Frankl's approach to value problems has been discussed by Weisskopf:[3]

> Many religions have stressed the positive value of suffering. Since suffering is inevitable, it seems much wiser to adopt a philisophy of life which accepts a certain amount of suffering or even gives it a positive value. Our current mental-hygiene philosophy, on the contrary, stresses the idea that people ought to be happy, that unhappiness is a symptom of maladjustment. Such a value-system might be responsible for the fact that the burden of unavoidable unhappiness is increased by unhappiness about being unhappy!

In his pursuit of values, man is necessarily confronted with the problem of meaning; with the question of what life is all about; of the relationship between happiness and values. Values are interrelated; no one value is isolated from another. Each has meaning in relation to the whole self. Consequently, a well-balanced scale of values leads to better personality integration and as such would constitute a basis for mental health.

To summarize, it is evident that values determine what we do with our lives. They contain our conception of what makes life good and they strongly influence decisions in every situation so that the individual's life is spent acquiring and realizing values through daily acts.

Thus a man who sees himself endowed with the responsibility to realize values can live from a basis of deep respect for himself and for all other men.

MARGUERITE MORIN, M.SC.N.

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THE TEACHING OF NURSING ETHICS

S. R. LAYCOCK, PH.D.

INTERNATIONAL CODE OF NURSING ETHICS

Professional nurses minister to the sick, assume responsibility for creating a physical, social and spiritual environment which will be conducive to recovery, and stress the prevention of illness and promotion of health by teaching and example. They render health service to the individual, the family, and the community and coordinate their services with members of other health professions.

Service to mankind is the primary function of nurses and the reason for the existence of the nursing profession. Need for nursing service is universal. Professional nursing service is therefore unrestricted by considerations of nationality, race, creed, colour, politics or social status.

Inherent in the code is the fundamental concept that the nurse believes in the essential freedoms of mankind and in the preservation of human life.

The profession recognizes that an international code cannot cover in detail all the activities and relationships of nurses, some of which are conditioned by personal philosophies and beliefs.

1. The fundamental responsibility of the nurse is threefold: to conserve life, to alleviate suffering and to promote health.

2. The nurse must maintain at all times the highest standards of nursing care and of professional conduct.

3. The nurse must be well prepared to practice and must maintain her knowledge and skill at a consistently high level.

4. The religious beliefs of a patient must be respected.

5. Nurses hold in confidence all personal information entrusted to them.

6. A nurse recognises not only the responsibilities but the limitations of her or his professional functions; recommends or gives medical treatment without medical orders only in emergencies and reports such action to a physician at the earliest possible moment.

7. The nurse is under an obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures.

8. The nurse sustains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed but only to the proper authority.

9. A nurse is entitled to just remuneration and accepts only such compensation as the contract, actual or implied, provides.

10. Nurses do not permit their names to be used in connection with the advertisement of products or with any other forms of self advertisement.

11. The nurse co-operates with and maintains harmonious relationships with members of other professions and with her or his nursing colleagues.

12. The nurse in private life adheres to standards of personal ethics which reflect credit upon the profession.

13. In personal conduct nurses should not knowingly disregard the accepted patterns of behaviour of the community in which they live and work.

14. A nurse should participate and share responsibility with other citizens and other health professions in promoting efforts to meet the health needs of the public — local, state, national and international.

The Canadian Nurses' Association, at its convention in Banff in 1954, adopted the International Code of Nursing Ethics. The question of how

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to make sure that the standards, values and attitudes of the Code become incorporated into the daily activities of student nurses and practising graduate nurses is of great concern to those responsible for nursing education.

The problem of the teaching of nursing ethics is largely that of training in relationships — that is, in relationships with patients, their relatives, doctors, supervisors, colleagues, aides, orderlies and the public. Since these relationships have an emotional basis in the attitudes, values and standards of the student nurse, they are tied in with her fundamental character and personality traits. They are, therefore, more difficult to develop than any new knowledge and skills.

Self-Concepts are Important

Psychologists today are placing increasing emphasis on the individual's self-concept as a determinant of his behavior. How a student nurse thinks of herself as a person — as accepted or rejected, worthy or unworthy, successful or unsuccessful — determines how she perceives others' reactions to her as well as how she reacts to them. It also determines how she tackles life's daily problems. Because of this, the student nurse needs to have a healthy self-concept. She needs to be an emotionally mature person who, in mental health terms, feels reasonably comfortable about herself, feels right toward others, and is able to handle the day-by-day problems of her professional tasks and relationships. The insecure and emotionally immature nurse is unlikely to give her patients the emotional support they need; to accept authority from doctors and superiors without resentment; to treat ancillary personnel with courtesy and consideration; to order her own life so that she commands the respect of her colleagues, the profession and the public.

What, then, can be done to ensure that student nurses (and practising nurses) will respond with emotional maturity to situations that arise in their professional duties?

Careful Selection of Candidates

Obviously, the most important factor in getting nurses to have a high standard of professional ethics lies in the careful selection of candidates for training. Recently a distinguished teacher-educator asked the writer, "How can I obtain a supply of student teachers who are basically warm and kind persons; who are emotionally mature individuals; who are interested in and respect children; who are dedicated to teaching them?" My answer was, "Grow them!" By that I meant that the answer lies, first of all, in the child-rearing practices of the student teacher's childhood home and, secondly, in the kind of school life he had experienced at school. There is a weight of evidence that the basis for sound adult relationships is laid in the childhood of the individual by the home and school which should have fostered sound emotional growth if the individual is to have wholesome attitudes toward himself, others, and life's tasks.

From the above it follows that, in the selection of candidates for nursing, great emphasis must be placed on the emotional maturity of the individual as well as on her academic standing. However, having selected young women who are emotionally mature, what can be done specifically to help them to translate the code of nursing ethics into daily practice?

Telling is Not Enough

There is an old saying that a telling (talking) teacher is not a telling (effective) teacher. Lectures and drill in the classroom and in a practice situation may be reasonably effective in teaching certain types of skills and procedures but are likely to be relatively ineffective in changing the basic values, attitudes and ideals of student nurses. Nothing short of altering the self-concept of the student, especially as to how she conceives of her role as a nurse, may be required. To accomplish this will require attention to four factors:

1. The importance of the instructor's own code of ethics;
2. a case study approach in teaching;
3. an increase in the self-understanding of the student nurse through special seminars;
4. personal counseling for the student's own problems.

The Instructor's Code of Ethics

In elementary and secondary education it has been found that a stimulating and enthusiastic teacher can awaken in children almost any intellectual interest which is appropriate to their stage of development. In the moral and emotional fields the sharing of the teacher's own life is of even more vital concern. Children are likely to identify with important adults in their environment and to incorporate the latter's ideals, values and attitudes into their own lives. In nursing education, no amount of academic background or nursing experience on the part of the instructor in nursing arts can take the place of her deep commitment to the nursing code of ethics in the conduct of her own life. Choosing nursing instructors should (to paraphrase the marriage service) "not be entered into lightly or unadvisedly but reverently and discreetly." Certainly, student nurses are likely to be greatly influenced by their instructor's own code of ethics as displayed both in the classroom and on the hospital ward.

Use of the "In-basket Technique" in Teaching

In the training of teachers for the principalship of schools, educators make considerable use of the "In-basket Technique." In this, the student is presented with a basket of memos, reports and problems which a principal is likely to meet on the opening day of school and with which he has to deal forthwith.

In this method, abundant use is made of a variety of recordings of interviews with parents and of contacts with fellow-teachers, subordinates, and pupils, as well as of films showing teachers teaching, handling difficult discipline problems, and dealing with Parent Teacher Association meetings and with visits of supervisors.

Suitably modified, this technique could be employed with good effect in the education of student nurses. Presented with a series of situations and problems involving any of the relationships which they will meet, both as students and as graduate nurses, the students are required to indicate how they would deal with these developments. The use of group discussion and/or written answers is desirable. Ward supervisors could make note of actual examples in the relationships of the student nurses and these could be evaluated by the class. In using films and recordings, student discussion is an essential aspect of the teaching process.

Role-playing

Another device of great value in the teaching of relationships is that of role-playing. Two (or more) students are given a skeleton problem or situation and, after two or three minutes' preparation, are asked to play, for not more than five minutes, the parts of student nurse and patients, colleagues, supervisors, doctors, nursing aides or orderlies. The role-playing and the discussion which follows help to give insight into various aspects of the relationship of the nurse.

Seminars in Self-understanding

Psychologists believe that parents should have some insight into why they react to their children the way they do. Whether the parents are over-dominant, over-protective, inconsistent in discipline, fearful or dithery, the cause is to be sought in their early experiences. This is true also of teachers. In an attempt to increase the self-understanding of teachers, seminars are held where teachers are encouraged to discuss why they react to their pupils the way they do (e.g., by sarcasm, nagging, domination, social or racial bias).

In the same way, seminars for student nurses can be provided where the students can explore the reasons why they react in various ways to patients, colleagues, doctors, supervisors, aides and orderlies. This should help them to understand themselves and their role realistically. It gives them the opportunity to alter their perception of themselves and others. It can modify their self-concept and their perception of their ideal self as a nurse. The seminar should consist of a small group and should be conducted by a trained group leader rather than by a regular instructor or other authority-figure so that students may feel free to reveal, work through, and modify their real feelings. Otherwise they will not feel

that they can "let down" to someone on whom their course standing and future recommendations depend.

Counseling Service for Students

All normal human beings have, from time to time, personal problems for which they need help. Counseling service should, therefore, be available to both student and graduate nurses. For many types of problems this service should be outside the jurisdiction of and (except in unusual circumstances) should not be reported to the nursing school authorities. A "Well-being Clinic," as it now exists in at least one Canadian city, would be ideal for this purpose. Certainly, early counseling for those with emotional problems could lead not only to the solutions of such problems but also to increased self-understanding and a modified self-concept. Arrangements for counseling could be made by nursing associations rather than by the schools of nursing.

Summary

Many professional skills, techniques and procedures of the nursing arts can be taught in lectures and in supervised practice. When it comes to developing the standards, attitudes and values of the nursing code of ethics, something more is required. Since this is a matter of improving the student's professional relationships it usually involves a modification of her self-concept and her perception of her ideal self as a nurse. In addition to a highly ethical "climate" in the nursing school and hospital, which exemplifies the code of ethics in practice, the use of the case study approach is recommended. Moreover, the use of role-playing and the provision of special seminars can help to increase the self-understanding of the student nurse and modify her self-concept. The provision of counseling services can assist the student nurse to solve her problems and to understand herself. This can lead to greater emotional maturity and, consequently, improve the student's sense of responsibility to others which, after all, is the basis for all sound human relationships.

In the Good Old Days

(The Canadian Nurse — DECEMBER, 1924)

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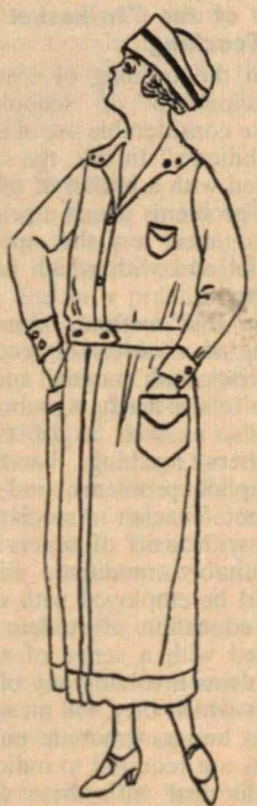

* *We don't know why!* Ed.

PERSONALITY AND ADAPTATION

SISTER CÉCILE LECLERC

A discussion of the factors that affect personal adjustment.

Introduction

Our modern world is full of scientific wonders. Man has conquered space with electronics and rockets; scientists predict that an "amazing world awaits us just over the horizon, a world that is challenging, exciting and promising."[1] Developments that once would have required many years to achieve are compressed into a few months with the ever-increasing tempo of progress. No one would dispute the fact that we are living in a time of rapid change. Changes in society are bound to bring changes in the people who compose it. How does advancing technology affect human behavior? Dr. Lehmann ventures that "in the face of all these undreamed-of achievements and success, our society is not becoming more confident but more bewildered. Humanity is not a healthy and carefree lot, but people are sick and live in an anxious world,"[2] made even more complex by scientific development.

That mankind is subject to stress and strain is a well-known fact. It is recognized that this stress is due primarily to circumstances in his environment and to the inner conflicts of his personality.

Personality and Adjustment

Dr. Gordon Allport suggests that personality is constantly developing and changing and is made up of determining tendencies that play an active role in the individual's behavior and his adaptation to his environment.[3]

This points to the fact that although environment exerts an influence on an individual, his reaction to his environment will be determined primarily by these inner unique tendencies. Allport, in his theory of personality, places strong emphasis on the potentialities of the individual to adjust. He defines personality as:

the dynamic organization within the individual of those psychophysical systems that determine his unique adjustment to his environment.[4]

This theory should represent to nurses a scientific verification of empirical knowledge acquired in nursing practice, provided that they have been more interested in the person who is ill than in the illness of the person.

It would seem advisable, at this point, to identify the meaning adopted for this discussion of the terms "adjustment," "adaptation," and "environment." The term *adjustment* is very often applied objectively to mean the evaluation of the extent to which an individual's behavior conforms to social expectancy.[5] However, Allport's definition would seem to imply that adjustment is a dynamic, active process, a continuous process or striving to achieve personal adequacy.[6]

In fact, adjustment is mainly a subjective, active process that may be known to a certain degree through a study of human behavior.

Adaptation is the conscious and unconscious forms of adjustment to actual or supposed environmental conditions, past, present and future, which confront man.[7] . . . *Environment* consists of both that which is exterior and interior to man.[8]

A certain tendency still persists with some nurses to dichotomize man into entities — physical and psychological — and to see the patient as physically sick or emotionally ill. This dissociation in the nurse's mind about patients is easily reflected in her nursing care. Why does a nurse accept and respect biological or physiological maladaptation of the organism, such as unusual reactions to drugs, and label as "obnoxious" behavior that reflects a pa-

Sister Leclerc is presently completing her Master's degree in nursing education at the Catholic University of America in Washington, D.C.

tient's maladaptation to external environment? This is a rather typical example of the failure on the part of the nurse to acknowledge a person's "uniqueness of adjustment" at all levels. It is doubtful that the process of organic maladjustment is understood any better by the nurse than that of psychological maladjustment. It stems from the common agreement to allow people to differ from one another physically and biologically but freedom to differ psychologically is not always granted so willingly.

Many instances relative to difficulties in adjustment can be recalled as one looks in retrospect on numerous experiences encountered in nursing. For example, there was the patient who reacted to Butazolidin with such severe internal bleeding that her life was endangered. This was considered a very unique reaction, most puzzling. Complete scientific machinery was set up in an effort to unveil the "whys" of this reaction — the failure of the organism to adjust. Next room, another woman made *her* peculiarities known to all members of the staff. She was demanding; insisted on endless reassurance; did not like the way that she was treated. In other words she was "a difficult patient." In fact, some members of the staff labelled her as "a chronic complainer." One of the nurses decided to set up psychological machinery in an attempt to discover why the patient was having this peculiar reaction to her external environment. She discovered that the woman had been hospitalized some years previously in the maternity department. While there she had seen a patient in the same room hemorrhage almost fatally before the nursing personnel became aware of it. The picture became clear. A mixture of feelings — insecurity, lack of trust, and a sense of personal threat in the hospital environment — were at the root of her maladjustment. As Allport states

> the enigma posed by the complex individual is great as no two individuals make exactly the same adjustment to their environment because no two individuals have the same personality.[9]

Personality and Rehabilitation

The concept of the complexity and the uniqueness of an individual is fully endorsed by nurses in every field and confirmed by their innumerable experiences. However, it becomes more evident still in the field of rehabilitation. There are many definitions of rehabilitation. One authority states that

> it is the restoration of the handicapped to the fullest physical, mental, social, vocational, emotional and economic usefulness of which they are capable.[10]

Dr. Jousse, director of Physical Medicine at the University of Toronto, suggests that a sounder definition would be: "What needs to be done to get a person going following illness or injury."[11]

The problems of the disabled in society have been considered from many points of view. Fifty years ago, acute and often fatal epidemic disease occupied the attention and energies of the nursing and medical profession. The main concern was to save lives. Because death at all ages was so commonplace those who survived, even though disabled, were thankful for this blessing. Society did not expect them to be productive. Society could not offer then, as it does today, opportunities where the weak and the frail could produce in an economically worthwhile fashion. Work in a factory or on a farm required greater physical fitness since equipment was much less specialized than it is presently. However the disabled person's needs and potentialities for rehabilitation were the same then as now. Society may change but individuals react in the same fashion as they have done since the dawn of history, that is, in a "unique" manner. Irrespective of the degree of disability, the attitude and emotional reaction to the restraint imposed by physical disability is determined largely by the type of person who is involved. The individual's reaction to his handicap, his intellectual acuity, his former potential, his pattern of behavior, the strong points in his personality — that is, his ability and his pattern of adjustment to his environment — will constitute determinant forces in his rehabilitation.

About five years ago an honor high school graduate made application to enter the school of nursing of which I was the director. She mentioned in her letter that

she had had poliomyelitis when she was fifteen and that she still had to wear a brace to support her right leg. She insisted that she could walk considerable distances without experiencing pain or discomfort. She had dreamed of becoming a nurse since her grade nine days, her hope was that her handicap would not prevent her from fulfilling her ambition.

The increased emphasis on the importance of including the concept of rehabilitation in the curriculum of schools of nursing as well as the integration of rehabilitative care in the hospital, had made the administrative and teaching personnel of the school more aware of the necessity to assist handicapped persons to become happy and productive members of society. Opportunity was knocking at the door to test the beautiful concepts expressed in the objectives of the school and other concepts of human behavior in relation to rehabilitation.

The candidate was requested to report to the school for an interview with the director and with the chief of the orthopedic department in an attempt to assess her psychological and physical potentialities. Both interviewers, as well as the psychologist to whom she was referred, were greatly impressed with the high degree of motivation and determination displayed by the applicant. The orthopedist, however, was most reluctant to recommend her for admission since her pronounced physical disability did not seem compatible with the demands of nursing. Nevertheless, she was accepted by the school committee in view of her unusual motivation though her application had been rejected by 10 other schools of nursing. An agreement was signed by both parents and the applicant in which conditions of admission were stipulated. Within a year of her admission this student could walk without a brace and required only a few adjustments in her educational program. She now holds a baccalaureate degree in nursing and is a successful teacher.

It is a difficult task to trace the many and varied influences on a person's successful adjustment. Rehabilitation of the disabled is simple of concept but difficult of execution since the personal element determines the outcome. In their professional experience nurses have come to recognize, if not always to understand, that the degree of physical defect is easy to evaluate but the important point to consider is the type of person who suffers from it. It has been estimated "that two out of every hundred Canadians live at the expense of their families and communities as the result of physical disability."[12] Again one has to be reminded of the unique nature of each individual's reaction. It cannot be predicted! Although new developments in the behavioral sciences have broadened our understanding of human beings, nurses are very often puzzled by patients' reactions, especially in the rehabilitative process, since the success of their efforts appears to rest almost totally on the patient's own motivation.

To the extent that the pattern of motivation is unique and individual we may expect the pattern of adjustment to be unique, and in this sense all problems of adjustment must be regarded as distinctive and as transcending the general principles that govern the process of adjustment.[13]

Conclusion

Advances in science and technology have forced changes into our daily environment that sometimes tend to make it more complex. Since no two individuals react the same due to differences in personality, the degree of one's happiness will be in relation to his power of adjustment. Limitations in psychological adjustment depend upon the quality of the individual's psychological heredity and upon previous experience with important figures. These factors continue to operate by unconscious representation. The concept of adjustment is not an exclusive means of understanding all of the processes that the individual undergoes. However, it is useful in understanding the relationships between an individual and his environment, both internal and external. Allport indicates that it is personality that mediates between the individual and his physical and psychological environment, sometimes submitting to it, sometimes mastering it.[14]

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ANPQ MEETING

Over sixteen hundred nurses attended the 44th annual meeting of The Association of Nurses of the Province of Quebec, held October 28, 29, 30, 1964, in Montreal.

MISS G. LAMARRE, *1st vice-president, (Fr.) introduces co-chairmen of Committee on Labour Relations. Left to right:* E. M. MERLEAU, E. C. FLANAGAN, *and* M. M. WHEELER.

In her opening address, Miss Helene M. Lamont, president, pointed out that changes within our society must be met by changes within the profession; these changes, in turn, determine the course of action that the professional association must follow. The immediate tasks facing the Association involve nursing education, nursing service, and socio-economic relations.

Discussion the first morning concerned the Report of the Royal Commission on Health Services. The keynote speaker, Dr. Victor Goldbloom, vice-president, Quebec College of Physicians and Surgeons, emphasized the importance of studying the Report and its implications objectively. "The specific introduction of a health care plan," he stated, "should be a piecemeal undertaking. The attempt to establish a total program at one time would only invite delay, financial risk and conflict."

In a panel discussion of the Commission's recommendations concerning nursing, Mrs. A. Isobel MacLeod, director of nursing, Montreal General Hospital, stated that one important implication of the Report is that it will increase the demand for registered nurses. She stressed the need for more effective recruitment and educational programs to attract and prepare nurses for the specialized activities required of them.

Other members of the panel included: Miss Alice Girard, dean of the Faculty of Nursing, University of Montreal; Miss Noëlla Bertrand, director of hospital sciences, Laval University; Sister Denise Lefebvre, director, Institut Marguerite d'Youville, Montreal; Miss Gabrielle Charbonneau, public health nursing director, University of Montreal.

A "Labour Relations Day" was held on Tuesday as a follow-up of the April, 1964, Institute. Discussion focused on the variety of labor relations problems facing nursing today and on collective bargaining as a possible means of negotiation.

On Friday, Miss Elizabeth Logan, director of the School for Graduate Nurses, McGill University, spoke about "The Future Role of the Professional Nurse." Following this, a panel, chaired by Miss Joan Gilchrist, director of nursing, Jewish General Hospital, discussed development of inservice education programs.

Kidney Disease Due to Analgesics

JOHN B. DOSSETOR, B.M., B.CH., F.R.C.P.(C).

Evidence to support the fact that self-medication can be dangerous.

Various terms have been used for the entity about to be described: "phenacetin nephritis," "chronic interstitial nephritis," "pyelonephritis associated with abuse of analgesics." Closely allied, and describing one of the more common manifestations of the disease, are such entities as "renal papillary necrosis in non-diabetics" and "phenacetin papillary necrosis." Implied in these terms is the belief that analgesic preparations can damage the kidneys when ingested in excessive amounts. Phenacetin is a common ingredient of such pills and is believed by many to be the toxic factor.

It is very curious that such a common drug as phenacetin should only have been suspected as a cause of kidney disease in the last 10 years in Europe and only in the last two or three years in North America. As recently as February, 1963, Dr. G. E. Schreiner[1] of Georgetown Medical School, Washington, wrote to 74 nephrologists in North America asking them if they recognized this form of kidney disease and whether they had seen a case. All replied that they had heard of the entity (it would have been too much to have admitted ignorance!) but only 22 had seen a case. Altogether, they contributed only 58 cases, of which 15 were definite, 34 were probable and, in the remaining nine it was only possible that phenacetin was playing a role.

There are four reasons for the delay in recognition of this form of nephritis. One is that the analgesic preparation has to be taken in large amounts over a long period of time. Secondly, chronic renal insufficiency due to this cause is, like many other renal diseases, extremely insidious in its onset and may not give rise to any symptoms until 85 per cent or so of the kidneys has been destroyed. This may not occur for many years. It may reveal itself only in the form of hypertension and the renal etiology of the latter condition may not be recognized. Thirdly, the form of kidney disease is not associated with much protein in the urine; in fact, protein may be absent from the urine despite considerable kidney impairment. Fourthly, infection is a common complication of analgesic nephritis, leading to a diagnosis of chronic pyelonephritis, the underlying abuse of analgesics being overlooked.

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Historical Outline

Let us now consider in greater detail the evidence on which these statements are based. The first description of this renal disease was by Spuhler and Zollinger[2] in 1953, yet phenacetin has been a commonly consumed drug for over 50 years. They noticed further, that 22 of their 30 cases also had necrosis of the papilla of the renal medulla, this complication being found in 11 of 12 patients who died. No one knows the reason why the papilla should become so seriously involved in this disease; nor is it clearly established what role is played by superadded infection in causing the papilla to slough off. Renal papillary necrosis was believed to be a complication that occurred principally in diabetic patients when they had a severe urinary tract infection or with pyelonephritis in the presence of urinary obstruction. Lindeneg[3] reviewed 103 cases of renal papillary necrosis and found that 60 per cent of these had excessive intake of analgesic drugs. Larsen and Moller[4] questioned 698 consecutive admissions to hospital and found that 205 of these took phenacetin in one form or another every day. Only 19 had taken

one gram or more per day for more than a 10 year period; but 80 per cent of the latter had renal disease. A further report from Scandinavia by Nordenfelt[5] concerned 27 men and three women. There were 23 autopsies in this group and in 12 they found renal papillary necrosis. No less than 22 out of the 27 men were patients who had been working in a certain factory where many employees repeatedly ingested Hjorten powders. Each powder contained 0.5 grams phenacetin, 0.5 grams of phenazone and 0.1 grams of caffeine. The popular opinion in the factory was that these powders stimulated one's ability to work and, therefore, helped to obtain higher wages.

This disease has now been widely reported from South Africa, Canada, New Zealand, and Australia as well as an increasing number of publications from the United States.[6, 7, 8]

Etiology and Pathogenesis

The relationship between phenacetin and this form of renal disease has been based on simple observation. The way in which the drug causes renal damage is not yet established. The pathological features consist of: a. evidence of inflammation of the interstitial tissue (the tissue between the individual tubules); b. evidence of superadded pyelonephritis (a complication that occurs in many forms of renal disease); and c. necrosis of the papilla.

The mechanism of alleged nephrotoxicity seems to be most obscure. It seems to be dependent on the total accumulated dose (between 5 and 10 kg. of phenacetin must be ingested before this disease occurs). Since one analgesic tablet may contain 300 mg., the chronic analgesic pill swallower must take about 5 pills a day, or 1.5 grams per day. This amounts to 550 Gm. per annum which, if continued for about 10 years, gets into the range in which this form of kidney disease occurs. As might be anticipated, many of these patients have psychoneurotic problems, often with headache. An alleged unfortunate side effect of chronic abuse of phenacetin is that it may *cause* headache. This means that the patient may be taking phenacetin to relieve a phenacetin-induced headache!

Schreiner has cautioned against too glib an assumption that phenacetin causes kidney disease because it has so far been impossible to reproduce the disease in animals. He states:

> Nephro-toxicity may stem from one of these drugs, some combination of them or their natural metabolites; one drug may effect the metabolite of another and may produce an abnormal metabolite or delayed excretion; their toxicity may be synergistic or there may be a contaminant in the manufacturing process that results in the nephrotoxicity.

Clinical Presentation and Subsequent Course

As intimated above, the presentation of this disease is insidious. It may present as chronic renal insufficiency (gastrointestinal upset, anemia, itching, general lassitude, anorexia) or as hypertension and its complications (shortness of breath, orthopnea, etc.) or the disease may present with urological symptoms due to the slough of a renal papillus (unilateral renal colic or hematuria).

The cases that have been diagnosed to date have usually been those in which chronic renal insufficiency, with a rise in the blood urea nitrogen and serum creatinine, has already occurred. If the drug is withheld and the urinary tract infection controlled, the disease may be arrested. However, many patients have gradually progressed to fatal uremia. It is probable that, with earlier recognition, this disease may be arrested and may even improve following the cessation of analgesic abuse.

Size of the Problem

How much of a medical problem is analgesic nephritis? It is certain that most people take these compounds at moderately frequent intervals throughout their lives. Moeschlin has estimated that about 2 per cent of people take excessive quantities of analgesics. The incidence of the disease in its milder forms has not yet been defined. Until such definition is made, it is impossible to say to what extent the "ordinary" use of analgesics containing phenacetin might be nephrotoxic. It is probable that negligible toxicity occurs from "ordinary" usage.

It may be necessary to do no more

than caution users of phenacetin-containing compounds, by means of the label on the bottle, that excessive intake might cause kidney disease.

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ORAL HYPOGLYCEMIC AGENTS

GERALD E. SINCLAIR, M.D.

An up-to-date report on those agents currently in use, their effect, and the type of diabetic who can be controlled by them.

In 1942, the hypoglycemic effect of sulfonamides was first observed; by 1955, the first oral hypoglycemic drug was introduced into clinical use in Germany. This agent, Carbutamide, while still in use in some parts of Europe, was withdrawn from further trial in North America in 1957 because its use showed a high incidence of toxicity.

At the present time, although other drugs are undergoing clinical trial, three drugs are generally available for routine clinical use. These include two sulfonylurea compounds, *tolbutamide* (Orinase, Mobenol) and *chlorpropamide* (Diabinese), together with a biguanide compound, *phenformin* (DBI). The biguanides are totally unrelated to the sulfonylureas and have a different mode of action.

The development of these drugs represents a major advance in the field of diabetes, no less because of the stimulus to research, than in their usefulness as therapy in the maturity-onset, stable, ketoacidosis-resistant diabetic patient.

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Sulfonylurea Compounds

These agents appear to act by their effect on the pancreas in stimulating the secretion or release of insulin, or both, from the islet cells. An additional mechanism of action in part might be due to inactivation of the enzyme insulinase, which is involved in the degradation of insulin. Accordingly, endogenous insulin production is a prerequisite to the effective use of these agents. *They have no effect in the juvenile-onset, unstable, ketoacidosis-prone patient, nor where the pancreas has been removed.*

Tolbutamide is the most widely used compound, with the lowest incidence of side reactions. Although gastrointestinal side effects occur, generally the drug is extremely well tolerated. It is slowly but completely absorbed from the gut, reaches a peak serum level in two to four hours, and is excreted in the urine as a metabolically-inactive derivative. The half-life, i.e. the time required for the serum level to fall by 50 per cent, is four to eight hours. Accordingly, multiple doses are required. The dose range varies from 0.5-3.0 Gm. daily.

Chlorpropamide is also completely

absorbed, reaching a peak serum level in two to four hours. Unlike tolbutamide, it has half-life of 35 hours; thus a single dose may be effective for the 24 hours and cumulation may occur. A proportion of the drug is excreted in the urine unchanged. Prolonged action is not necessarily a desirable feature, since prolonged and severe hypoglycemic responses have occurred, with occasional fatalities. The development of cholestasis with jaundice represents a significant side effect, practically never observed with tolbutamide. Jaundice does not often occur, however, where the daily dose does not exceed 500 mg.

An occasional side effect, observed at times with either drug, is facial flushing after the ingestion of alcohol. This seems to be more common with chlorpropamide.

Biguanides

Phenformin is well absorbed, with the hypoglycemic effect lasting six to eight hours. The action can be prolonged by the use of timed disintegration capsules (DBI-TD). In addition, the latter tend to exhibit a reduced incidence and degree of the only important side effects, namely nausea, anorexia, vomiting and diarrhea. These symptoms will invariably occur if too large a dose is given; therefore, the maximum tolerated dose is limited to 200 mg. daily or less, in most cases.

The pancreatic islet cells are not essential for the action of phenformin. Accordingly, a hypoglycemic effect may be seen in all types of diabetes. Interestingly, this drug has no hypoglycemic effect in non-diabetic humans. The exact mechanism of action is still undefined. It has been suggested that the biguanides act by increasing intracellular glycolysis.

Clinical Indications

None of the oral hypoglycemic agents presently available can replace insulin in the juvenile-onset, unstable, ketoacidosis-prone patient. The sulfonylurea compounds are totally ineffective under these circumstances, while biguanides, where used, are given in conjuction with insulin therapy, in an attempt to smooth the control of labile diabetes.

The major usefulness of presently available oral agents appears to be in the control of maturity-onset, stable, ketoacidosis-resistant patients, beyond the age of 40 years. These drugs do not obviate the necessity for strict dietary control nor for weight loss in obese diabetics. Many elderly, stable, obese diabetics can be controlled by dietary means alone. Ideal candidates for oral hypoglycemic drugs are patients who remain uncontrolled following weight reduction while on an adequate diabetic diet, and whose insulin requirements are less than 40 units daily. It is common practice to initiate therapy with an oral agent prior to the attainment of ideal weight. The drug can at times be dispensed with when dietary control seems adequate.

Approximately 50 per cent of suitably selected patients can be adequately controlled with diet and tolbutamide. Therapy must be continued for a month before final assessment is made. Where control does not result, a primary failure has occurred. With the passage of time, control is lost in a small number of patients. These are termed secondary failures. Although a few of these may respond to chlorpropamide, a trial of phenformin would be indicated.

Because of the differing modes of action, patients who achieve only a partial response with a sulfonylurea compound may be controlled by the addition of phenformin to the regime. In the presence of infectious or surgical complications, or where ketoacidosis develops, these agents are not effective and control with insulin may be required.

Summary

Oral hypoglycemic agents, consisting of a sulfonylurea compound alone, or together with a biguanide, represent an effective method of blood sugar control, in conjunction with diet. Suitable patients are those beyond the age of 40 years, having an insulin requirement below 40 units daily for control of their maturity-onset, stable, ketoacidosis-resistant diabetes. In addition, phenformin may be effective, in conjunction with insulin, in smoothing the control of juvenile-onset, unstable, ketoacidosis-prone patients.

WHAT HAVE YOU TO DECLARE?

RAE CHITTICK, M.A., LL.D.

Like the custom's man's inquiry of a traveller at the border — what have you to declare? What are you taking with you? What treasures? What useful things? How much knowledge? How much intelligence? What abilities? What skills of efficiency?

An annual meeting is much like a commencement exercise. It is a convocation when members come together to hear reports on what has been done and to plot a course of action for the future. It is in these meetings that goals are set and routes mapped out to reach them. It is an opportunity to declare, as an organization and as individuals, what we have accomplished and what we plan to do in the future. Too often we have little to declare, either as an organization or as individuals. It is true that certain tasks have been accomplished, but have we moved ahead in acquiring new knowledge? Have we used our intelligence to relate known things to things that are as yet unknown in order to produce new ideas? Have we acquired additional abilities or become more efficient in our jobs? Are we serving the public better than we did last year?

This discussion is centred around professional organizations and what they have to declare. In the past their voices have been too small and their declarations too weak to be heard outside their own boundaries. In the 30 years that elapsed between the publication of Dr. Weir's Report, *A Survey of Nursing Education in Canada* and Dr. Mussallem's *Spotlight on Nursing Education,* there has been much talk, mostly among ourselves, about improvement of nursing education, but it suffers still from many of the same weaknesses that were pointed out by Dr. Weir. Yet in seven of the ten provinces, nursing organizations control, at least in theory, the education of nurses. Professional organizations have never had enough strength and unity to speak with sufficient conviction and authority so that their declarations would influence the public.

Now a new authority is arising. There is grave danger that professional voices will be drowned out entirely and that no sound at all will be heard.

> But answer came there none
> And this was scarcely odd because
> They'd eaten every one.

Dr. T. P. Morley suggested this title from the "Walrus and the Carpenter" for his article in the March 1963 issue of *Hospital Administration in Canada.* The allusion being, he said, that the nursing profession is unable to express an opinion of its own; it's been eaten up by administration — like the oysters, without a struggle.

Trained business executives are rising up all around us to manage our hospitals and our provincial insurance plans. These business men are having a great deal to say about nursing. While they have an important part to play in our health services, they should not be the authorities speaking for nursing. Nurses need to provide much more leadership and, in fact, our professional organizations have a legal responsibility to do so. Because professions have a statutory basis in the law of the country, a mutual exchange of definable values between the state and the professional group has been created. By statute a professional group is granted the exclusive right of performance in a specified field. In return for this monopolistic right there is a reciprocal commitment to

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give society the very best service that it is possible to provide.

What is a profession? What are its characteristics? What sets members of a profession apart from those in other vocations? In the early part of this century Abraham Flexner, who was so successful in upgrading medical schools, set down his criteria for a profession. He said that a profession is learned in nature with large individual responsibility and that its members constantly resort to the laboratory and seminar for a fresh supply of facts. The members are not merely academic or theoretical, but are definitely practical in their aims. They are self-organized with activities, duties and responsibilities which develop group consciousness. They are responsible to public interests and tend to become increasingly concerned with the achievement of social ends.

Ralph Tyler, the well-known educator, has said that there are two essential characteristics of a profession: The existence of a recognized code of ethics, and techniques of operation based upon principles rather than rule-of-thumb procedures or simple routine skills. In other words, professional activities involve complex tasks which are performed by artistic application of major principles rather than by routine operation of skills.

Professions do not start out this way. Some, such as law, medicine and divinity, go so far back in history that we have almost forgotten how they began. In the beginning the task is defined by society but, as the workers become more skilled, they first define the method of performance and then the task itself. In time, they modify, enlarge and redefine the tasks for society. As they advance towards a true profession, members of the group assume more and more responsibility for informing the public generally about their work, the importance of the task, the nature of quality performance and the like.[1]

At this stage in the development of a profession, that is, in asserting the importance of the task and in working for the achievement of quality performance, a profession must recognize conflicting interests and seek to maintain and support its own interests. This is not through any desire for self-aggrandizement, but because of the conviction that the ideas to be developed are for the benefit of society — the essence of the ethical code of a profession. This is a final stage in the development of a profession and it is at the level of statesmanship. At this stage the profession is concerned with the comprehensive improvement of total society. It takes cognizance of all other services, such as education, recreation and welfare, and seeks to develop a harmonious whole or the realization of the "good life." Tyler speaks of this stage as the frontier to be conquered. In our dynamic society this is likely to be an ever-changing frontier with no final conquest.

Having outlined the characteristics of a profession, I should like to look at nursing in the light of these criteria. Let us go back to Flexner's first principle, "a profession is learned in nature with large individual responsibility and their members constantly resort to the laboratory and seminar for a fresh supply of facts." I do not think that nursing is a learned profession because our body of nursing knowledge is extremely limited. Furthermore, we are *not* constantly adding new knowledge by resorting to the laboratory and seminar despite the fact that we have at hand the finest laboratory any profession could ask for — the hospital ward.

There is a unity in all knowledge and we must be familiar with other disciplines in order to build new knowledge in nursing. Medicine, for example, turns to chemistry, physics, engineering, sociology, psychology and other areas of knowledge in advancing the science of medical care. Our profession has not been so successful in using these disciplines to build new knowledge. Our changing social structure is promoting so many advances in health services that there is an urgent need to develop new ideas in nursing care. These involve engaging the patient and his family in both prevention and treatment; nursing in long-term illness; making rehabilitation, in both its mental and physical aspects, a part of all nursing care; learning to use the self in this complex helping relationship.

We might well ask, what are the obstacles in advancing the art and science of nursing? One of the chief reasons is that our members have not sufficient general education to use the various disciplines to advantage. They do not see relationships, make references, formulate assumptions or hypotheses and follow them through to a conclusion. It is one of the intrinsic effects of a good liberal education that it increases an individual's capacity to learn from experience. Learning from experience does not mean becoming more skilful in doing the same tasks. It means discovering better ways of doing things which may result in changing the task or eliminating it entirely. Part of our failure to develop new knowledge lies in the pattern of nursing education that is vocational rather than professional. Our method of education prepares the nurse for set practices and fixed relationships. We are so anxious to make our students safe to practice in the shortest time possible that we emphasize rule-of-thumb procedures and routine skills rather than the development of concepts and principles. Consequently, we have failed to develop those qualities that promote discovery, such as flexibility in thinking, critical perception and the ability to synthesize known facts into new ideas.

If I could put it another way, we are failing to make the members of our profession creative. Robert Ulich defines creativity as

> an act that changes the environment of man for the better, that pushes one or several persons ahead, that produces more favorable conditions for humanity, or that deepens our insight into ourselves while it widens our intellectual horizons.[2]

In general, the kind of teaching we do is designed to fit the nurse to work efficiently in the situation as it now exists. We look at performance rather than promise. We fail to recognize that the more creative the contribution, the more it shakes the framework on which current thinking and action are based.

It has been said that everybody takes sides in social change if it is profound enough. This is true of nursing. One of the profound questions facing the profession is: Who should be educating nurses? Should nursing students be educated in hospital schools, independent schools, technical institutes or universities? Members of our professional organizations are certainly taking sides in this issue. Yet, in actual fact, there is agreement, theoretically at least, in that the Canadian Nurses' Association in its submission to the Royal Commission on Health Services recommended "that the education of nurses be under the jurisdiction of institutions whose primary function is education." The CNA represents the combined voice of nursing for Canada, so what we are all saying is that nursing belongs in the framework of general education in each of the provinces.

In this respect at least every professsional organization has made a declaration. Yet this recommendation may never be implemented because we lack professional solidarity. Our own members will undermine efforts towards its realization either by doubting its practicality or by refusing to participate actively in experiments to test its value. There is a time to take sides, to express one's point of view, but *there is also a time to forget one's doubts and actively support what one's professional organization has agreed to do*. We have in nursing too much negativism which supports too many critics and not enough people *doing* things. We do not have enough of the true professional attitude that encourages experimentation and withholds judgment until all the results are known.

It is true that we have moved a little distance from the time when the late Kathleen Russell, formerly director of the University of Toronto School of Nursing, had to go around to the hospitals begging directors of nursing to hire the graduates of the School and give them a chance to show what they could do. Yet, our membership in general does not welcome innovations. It is too prone to find the weak areas in new departures. As Mrs. Duncanson, the director of the Nightingale School, stated in a press interview, "We'll certainly hear of our mistakes — we may not hear of the good." Unfortunately much of the harmful

criticism will come from our own profession.

This is another place where professional organizations must make a declaration — that experimentation is part of our professional responsibility and that if we are to grow as a profession, each member is responsible for creating situations where discovery can take place. Along with this we must cultivate a truly scientific attitude that anticipates failure as well as success and learns from both.

There is another and very important aspect of this declaration of professional organizations. It has to do with creating tensions between itself and society. Tensions are valuable and there probably ought always to be a tension between society and any kind of independent professional organization within it. It may be the duty of a professional organization to keep up its side of the tension because professional organizations are not instituted to reflect current ideas or popular desires, but to be independent of immediate utilitarian ends in its search for truth or excellence. As I stated earlier, a profession must define its task, assert its importance and work for the achievement of quality performance. In doing so it must recognize conflicting interests and seek to maintain and support its own interests, for if we are a true profession these interests are designed to improve our contribution to society.

I think we fail in our responsibility to create tensions between ourselves and society. We are a passive lot, afraid of conflict. We wait until society makes demands because we fail to meet our obligations and then we go to work to patch up the old system in a timid fashion, so that there is some change or diversity on the surface, but a great sameness beneath it. There is no doubt that this attitude prevails because we have not developed strong professional organizations. We have too many members who are not well informed, who do not understand the function of a profession and who do not actively participate in promoting the goals of the organization. Certainly the medical profession has done much better than we in this respect.

There is a very urgent need to strengthen our professional organizations both for the welfare of our members and the development of the nursing profession in Canada. Certainly, guarding the interests of our members' remuneration is a vital problem. Regardless of our high ideals of service, salaries determine what we can spend on continuing education and the fees we can afford to pay our professional organization to promote the improvement of nursing service. Also, in the long-run, the salary range will determine the calibre of students that we can attract into the profession. We are only human and we expect to be paid for our abilities.

Hospital insurance commissions set ceilings on nurses' salaries which have grave implications for our professional organizations. Dr. Neilson of the Ontario Hospital Service Commission stated, "We limit the salaries of nurses in the sense that we do not go beyond a certain maximum in what we approve."[3] This means that nurses cannot sell their services in the open market. It ignores the recommendations of the professional organization whose responsibility it is to protect its members. Dr. John Crispo of the University of Toronto, speaking at an RNAO meeting said, "Nurses today have 'begging' rather than 'bargaining' power." He advised the Ontario association to obtain legal right for compulsory arbitration as the only way the nursing profession can protect its integrity. Such a move by a big organization such as the RNAO could be a declaration of professional responsibility towards all nurses.

There are other alarming developments to which professional organizations must give leadership. One of these is the rapid rise of the nursing assistant group. This is the fastest growing nursing program in Canada, as it is in the United States. In 1958 we had 19 English-speaking schools for nursing assistants; in 1961 we had 39. The number graduating rose from 674 in 1958 to 1382 in 1961. At least one province is graduating more nursing assistants than professional nurses. Are we coming to the time when many hospitals will be staffed largely with nursing assistants? What are the implications of this for the graduate

nurse, especially with the continued improvement of nursing assistant programs?

In rumors that are growing out of the Federal Government's study of recruitment, it would seem that we are not getting our share of top high school students into nursing and that the ratio of students entering university schools to those entering hospital schools is declining. Considering the great number of poor hospital schools in Canada and our great need for better prepared instructors and administrators, this is a serious state of affairs.

We seem to be following the same trend as in the United States, but at a somewhat slower pace. We could learn from the serious study by the Surgeon General's Consultant Group on Nursing. The members declared that the profession is not keeping abreast of fast-changing health care needs and set down seven important problems:

Too few schools are providing adequate education for nursing.

Not enough capable young people are being recruited to meet the demand.

Too few college-bound students are entering the nursing field.

More nursing schools are needed within colleges and universities.

The continuing lag in the social and economic status of nurses discourages people from entering the field and remaining active in it.

Available nursing personnel are not being fully utilized for effective patient care, including supervision and teaching as well as clinical care.

Too little research is being conducted on the advancement of nursing practice.[4]

We are facing some big problems in nursing — problems that can only be dealt with by strong professional organizations. If we are to formulate forceful policies and declare them with conviction, we must have the active and enthusiastic support of all our members. If membership in a profession means large individual responsibility, we must constantly assess what this involves and recognize that it includes the responsibility to be well informed, to advance our own knowledge constantly and to work collectively for the advancement of nursing in the future.

In conclusion, I should like to give you a bit of Walt Whitman's philosophy which comes from his poem, "Song of the Open Road."

Now understand me well — it is provided in the essence of things that from any fruition of success, no matter what, shall come forth something to make a greater struggle necessary.[5]

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TOLBUTAMIDE TABLETS

It has been reported recently that diabetic patients who have been controlled adequately with a given dose of tolbutamide, went out of control as a result of taking a different brand of tolbutamide tablets . . . . [This prompted an investigation to determine] the reasons for such incidents and to indicate possible ways of preventing similar incidents in the future . . . .

The following recommendations [were made]:

1. It is recommended that diabetic patients, once their condition is under control with a given dosage regimen of tolbutamide, should not be switched to another brand.

2. If a change to another brand of tolbutamide cannot be prevented . . . one must apply the same precautions as are used when changing from one anti-diabetic agent to another . . . . — *Canadian Medical Association Journal*, 90:978, April, 1964.

LEGAL RESPONSIBILITY

E. JACQUES COURTOIS, Q.C.

A lawyer looks at legal responsibility in the field of nursing.

Responsibility is the cornerstone of judicial structure. A prime function of law is the maintenance of a balance in relationships between individuals, compelling those responsible for damages to make amends to the injured parties. Responsibility and error are inseparable since the latter creates the former. Error must be proven before legal redress can be sought.

Error has both a legal and moral connotation which makes definition literally impossible. In very general terms, error is the failure to observe a pre-existing obligation which implies that there are as many occasions for charging error in law as there are obligations under it. For purposes of practical application, the law has established criteria on which the courts take their stand — that of the "Bon père de famille" — the prudent administrator — the ideal citizen, intelligent, thoughtful, reasonably careful. It is to this concept that we turn in weighing the moral worth of an action: Is this the act of a reasonable man? If the action in question does not meet this criterion, then the individual is considered at fault and responsibility is incurred.

In this province, responsibility is defined by Article 1053 of the Civil Code of the Province of Quebec:

> Every person capable of distinguishing right from wrong is responsible for the damage caused by his fault to another, whether by positive act, imprudence, neglect or want of skill.

In the performance of her duties, the nurse is subject to the common regulations of law. This means that when she is proven to be at fault, she incurs responsibility according to the foregoing criterion based on the concept of the ideal citizen. In this instance, the concept includes concern for the well-being of others and a reasonable degree of knowledge and skill in the rules of medical art. The court must then evaluate the moral value of the nurse's actions for which it is desired to hold her responsible and determine whether or not they are the actions of a good citizen. This is an example of the practical application of the law under circumstances that encompass a minimum of problems. In practice, however, most cases are much more complex and solutions to them much harder to achieve.

Generally speaking, a contractual or quasi-contractual relationship between patient and nurse does not exist. In general the hospital acts as intermediary between the two, as employer of the nurse and under obligation for the care of the patient. Consequently, the concepts of master and principal require further emphasis.

Article 1054 of the Civil Code, paragraph 1, states:

> He (any person) is responsible not only for the damage caused by his own fault but also for that caused by the fault of persons under his control and by things he has under his care.

Practical application of this rule has, on occasion, resulted in our courts holding hospitals responsible for injury received at the hands of nurses in their employ. We must differentiate once more between the nurse who enters into personal legal relationships with a patient — as, for example, in private nursing — and the one who is in the

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employ of a hospital, under whose control she practises her profession. In the first instance, the principles of law discussed at the beginning of the article apply: If the nurse can be proven at fault, then she must assume responsibility and will be held for redress of the injury incurred. In the second case, if the nurse can be proven at fault, the hospital is jointly and severally held responsible with her. It is then necessary to produce additional proof of the control exercised by the institution over the employee. In addition, it must be shown that the error was made during the performance of her duties.

Court decisions in this respect are manifold and over the years a definite trend has developed. Application of the rule of law has become somewhat less rigorous. Where older suits had taken the stand that the personnel of a hospital were "employed" in the sense of the Civil Code and, thus, under the control of the employer, the absurdities to which this could lead soon became apparent. It was recognized that in most instances the employer did not have the necessary knowledge to give orders to his employees concerning the methods of performing their duties. Now, and in particular since the case of Cassidy *vs* Minister of Health in 1951, the following norm rather than the "control" is observed:

> The test will be whether the employee is subordinate to the managerial powers of the employer's organization. The reason why the employers are liable in these cases is not because they can control the way in which the work is done — they often have not sufficient knowledge to do so — but because they employ the staff, have chosen them for the task and have in their hands the ultimate sanction for good conduct — the power of dismissal.[2]

In application of the same legal principles, courts have, on many occasions, recognized that the control exercised over an employee may temporarily be in the hands of a third party. Such, for example, is the situation when a surgeon is assisted during an operation by nurses. He is in charge and orders must be taken directly from him. For the moment he is the master.

This principle was established by the renowned suit of Hillyer *vs* Governors of St. Bartholomew's Hospital in which it was declared that:

> The relationship of master and servant does not exist between the governors and the physician and surgeons who give services at the hospital, and the nurses and other attendants assisting at an operation cease for the time being to be the servants of the governors, inasmuch as they take their orders during that period from the operating surgeon alone and not from the hospital authorities.[3]

When a case involves an employer-employee relationship and error is proven, it is imputed to the master and he incurs responsibility jointly and severally with the employee. It is considered that he is at fault either as a result of negligence in the control exerted over the employee or as a result of carelessness in the choice of competent employees. These are usually the grounds on which legal action is brought against a hospital or a surgeon. The latter must then prove to the satisfaction of the court that there has been no such negligence or carelessness.

The victim must provide proof of a certain number of essential points: the fact of error; injury sustained; and the relationship between the two. If the victim holds the employer responsible he must then, in addition to the foregoing, furnish proof of the control exercised by the employer over the offending individual as well as proof that the error was made during the performance of official duties.

Such are, in very summary fashion, the principles of law applicable in each case. Even with more extensive explanation and development, we could only succeed in treatment of one aspect of the problem. In fact, a study of this kind cannot be complete without a review of decisions rendered by the courts in cases where hospitals, doctors, nurses and patients have confronted each other. Each one of these suits is individualistic but, studied en masse, a certain number of principles to which the courts have had recourse can be isolated. It is worth remembering that medical jurisprudence applies, in most instances and without restriction, to the practice of nursing.

It is often difficult to demonstrate and prove error in medical practice unless it is of such magnitude that it is

tantamount to a "serious offence" — a polite term for what would ordinarily be termed a blunder. Under such conditions, evidence makes proof easier to demonstrate and, at the same time, lightens the work of the court. A number of cases involving determination of error and responsibility in the leaving of an instrument or a sponge in a patient's abdomen at operation have been cut short because even the simple good sense of the layman concerning medical matters was sufficient to reveal the mistake.

In the case of Trottier *vs* Rajotte, the Court of Queen's Bench ruled that

> The surgeon who, in the course of an operation carried out under normal conditions, forgets a dressing in the patient's abdomen, commits an error for which he is responsible.[4]

Similarly, the nurse, who, in the course of her duties, is called upon to give a diathermy treatment, commits an error if, instead of setting the machine for 750 milliamperes, accidentally sets it for 3,000 milliamperes and burns the patient severely. This was the decision of the Supreme Court of Canada in the Sisters of St. Joseph *vs* Fleming.[5]

Difficulties arise, however, when determination of error calls for the interpretation and application of medical theory. In such circumstances, the courts have adopted the policy of not intervening and not finding error when an action is presented as normal procedure for a theory or an opinion although it may be highly debatable. This principle is observed whatever may be the final results. The criterion, in this case, is the following:

> Blame cannot be attached to a mistake resulting from a controversial point.[6]

Thus, it can be stated that the nurse in the practice of her profession has full freedom to use her judgment and to act in accordance with her views in doubtful cases, while protected from prosecution in respect to responsibility. However, there must be certain reservations. This freedom must not be interpreted as conferring the right for the nurse to put her theories to the test and use her patients as guinea pigs. Where clearly-defined rules of medical procedure have been laid down, she must abide by them. However, just as with any science in evolution, and in particular those concerned with specific cases, medicine has no hard and fast rule to fit every case. In circumstances where several theories are opposed to one another or where several possible solutions are presented, the nurse has an opportunity to choose the one that accords with her reasoning even if the final result is disastrous for the patient.[7]

In the final analysis, the law does not require that the nurse should guarantee cure for all of her patients but that she should provide the care considered best by medical standards, or in doubtful cases, that she has used her judgment and her knowledge in the most appropriate way.

The courts take great pains to avoid any hindrance to the practice of the liberal professions. They carefully refrain from meddling in their fields of activity and intervene only when very obvious injustice occurs. Miss Blanche Rodet wrote:

> The powers of the judge come to a halt in the face of controversial questions. The blame that he holds in reserve has to do with non-compliance with the accepted rules of the art in question.[8]

It is with considerable reticence and always with great care that a judge will make up his mind to charge the individual engaged in medical practice with error.

The principles that can be deduced from our study of this whole subject may be summarized as follows:

> Nurses are subject to the common regulations of law in regard to responsibility, with due consideration for the distinctions that arise when the nurse is under the control of a third person.
>
> Error is not charged where controversy exists. The error must be evaluated in the abstract and it is a matter of indifference whether the consequences of an action be favorable or disastrous for the patient.

It is interesting to note that the relationship between two social functions as important as those of medicine and law require a minimum of interference and of clashes. In spite of the fact that legal action against members of the medical profession have multiplied in recent years,[9] the courts have, nevertheless, succeeded in maintaining a workable balance in this sphere of ac-

tivity. If the legislator has not hesitated to adopt laws creating statutory responsibility and facilitating indemnification of victims — for example, in the Motor Vehicles Act or in the Highway Victims Indemnity Act — he has also taken good care not to involve himself in an area where human activity, free from interference, is still inseparable from the concept of social service. Law could pay no better tribute to an art as old and noble as itself.

References

1. 1951, All England Reports, 574.
2. E. O. Fanjoy, 30 *Canadian Bar Review*, 424.
3. 2 K. B. 820.
4. 1938, B. R. 484.
5. 1938, 2 D. L. R., 417.
6. Planiol et Ripert, *Obligations*, Vol. 6, N. 525.
7. *Note:* Judge Mignault, in the judgment regarding Dupon *vs* St. Martin (1937, S. C. M. 127, 286) made the following comment, from which it can be concluded that this attitude stems not only from legal considerations but also from a concern to safeguard the social function of medical practice:

"It should be remembered that the practice of medicine and surgery is essential to the well-being of mankind; that it must not be hindered by too absolute rules of responsibility which would require a kind of infallibility on the part of the practitioner that he does not possess or which would compel him to give up his art; that if, in his case as in all others, error carries with it an obligation to make amends, one should not jump to the conclusion that the doctor is at fault and hence responsible when injury arises from medical treatment, since the facts of science are doubtful all too often."

8. *La reponsabilité civile des médecins et la jurisprudence actuelle, Paris 1937, p. 225.*
9. *Note:* The medical profession is not alone in its experience of this marginal effect of social development. The annals of jurisprudence report numerous suits, particularly within the last few years, involving members of the liberal professions, to say nothing of the various actions brought against the College of Physicians, the Bar, etc.

TREATMENT OF DIABETES MELLITUS

At the annual 1964 scientific meeting of the College of General Practice of Canada, Dr. Max Miller, associate professor of medicine and director of the Clinical Research Center of Western Reserve University, discussed the treatment of diabetes:

The use of drugs taken by mouth for the treatment of diabetes is increasing. Between half and a third of all diabetics are now on oral hypoglycemic agents. In Canada, the figure is lower than average — about one-third.

The discovery of these drugs has made a tremendous impact on diabetes treatment because basically people don't like injections. The plea of the patient when insulin was the only mode of therapy was always: "Can't I take something by mouth?"

To date, the major emphasis has been placed on lowering of the blood sugar. Evidence indicates that other problems exist for the diabetic patient. The most obvious one is that about 75 per cent die eventually of vascular lesions of the kidneys, heart and brain, not of diabetes. Eye defects are another problem with blindness resulting in some patients. To prevent this type of blindness, a new operation in which the pituitary gland is either removed or rendered inactive has been introduced in many centres. The effectiveness of this operation is still under study and it will take several years before its value can be clearly established.

DRUGS CONTAINING PHENACETIN

After considering reports on adverse effects resulting from the prolonged use of large doses of drugs containing phenacetin, the Canadian Drug Advisory Committee has recommended to the Minister of National Health and Welfare:

That the Food and Drug Regulations be amended to require the following warning to appear on the label of all drugs containing phenacetin, either singly or in combination with other drugs:

Caution: May be injurious if taken in large doses or for a long time. Do not exceed the recommended dose without consulting a physician.

A CHALLENGE FOR THE FUTURE

J. F. McCREARY, M.D.

Part of this challenge for the nursing and medical professions involves the "sharing of the spotlight" with other health workers.

The respect and dignity of the nursing profession which is so obvious today has been developed with great rapidity. We find little evidence of nurses in the history of medical care until about 200 years ago. By that time, the habit of bringing untrained and illiterate girls from the lower social order into the hospitals to serve as nurses was developing. The Sairy Gamp of Martin Chuzzlewit is a vivid and apparently accurate description of the nurse of that day. There was little evidence of respect, of dignity, of stability and esteem — no evidence of a training program. Nurses were servant girls of the lowest possible class.

Many things are responsible for the complete revolution which has occurred in the nursing profession during the past century. The introduction of training schools was perhaps the most important step forward. The concept that the nurse needed not only good training, but character and background, has resulted in a high degree of selection of applicants to nursing schools. Standards have risen within the profession. Advances in the science of healing, the development of asepsis, anesthesia and the consequent rapid progress in surgery, found the nursing profession accepting the responsibilities for new techniques and new procedures. Steadily and progressively, nursing has increased in importance. The two world wars have constituted a great impetus to nursing progress. Nurses have worked beside the physicians in the field and have risked their lives alongside the fighting men of our armies; they have thus earned the everlasting respect of their countries. The development of public health as a major part of medicine has meant much to nursing. Nurses have played, and are playing, a most important role in the prevention of disease. The nurse has proven her place in industry in the treatment of accidents, but, more important, in the prevention of illness — in keeping the working staff on the job.

It has been traditional that the professions of nursing and medicine be closely allied. Together, we have been able to make great advances in health care. True, in recent years, we have accepted help from other groups — physiotherapists, occupational therapists, clinical psychologists, social workers, etc. But these other groups have not really been part of the traditional nurse-doctor team. Certain forces exist in our part of the world and which will present challenges to nursing and to medicine.

The first of these forces is a growing sense of responsibility for a new concept of health. This is health — not in the sense of treatment of disease or infirmity — but health as stated by the World Health Organization. Under the guidance of public health trained physicians and nurses, this concept of health has grown in recent years.

In our professions, we must be acutely conscious of our limitations in promoting this type of health. We do not possess, and will never possess, all the skills and all the knowledge required to promote that complete state of physical, mental and social health which represents today's goals. We can, by working together, treat pneumonia and meningitis skilfully; we can assist in the healing of a fracture; we can be

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reasonably successful in the management of certain types of heart disease. Some, trained in psychiatry, can advise on the management of emotional and mental disease. Physicians and nurses cannot achieve for their patients the goal of excellent health in all respects.

Our greatest capabilities lie in the field of physical health. As we look toward the future, we can see little in the way of increased problems in this direction. In fact, the physical aspect of our task may become easier. New techniques of organ transplant may make it possible to trade in old hearts, kidneys, and livers, for new, just as we now trade in our old automobile tires.

It is in the area of emotional and social health that we face our greatest problems. In order to enjoy these, an individual must have many things. He must have a goal in life which is susceptible of achievement; he must have a job which consumes sufficient of his energy and drive, that his rest and his hobbies can fill his free time to capacity. He must not be bored; he must not feel that his life is meaningless. If we are to understand what is happening today to make this difficult to achieve, we must review the history of our work patterns.

Leisure time has been something available to only a favored few in the generations that have preceded us. In the distant past, the great mass of working people had no leisure. In 1800, the average work week was 84 hours. When we add to that 56 hours for rest and 21 hours for eating, there is little left of the week's 168 hours. There was no problem of leisure in those days. It did not exist.

In 1850, the work week had been shortened to 70 hours; by 1900 to 60 hours; by 1930 to 50 hours; most people now are working less than 40 hours a week. The four-day week of 32 hours is not far around the corner. So we face a new problem. Of a 168-hour week, 32 will be spent at work and 56 in sleeping. There are 80 hours left over — over 11 hours a day of leisure time, or over 3 full days a week completely unoccupied.

Further, the type of work now being done is, in the main, less likely to be satisfying and absorbing. It is rarely an individual effort. Fortunate indeed is the man or woman who, at the end of a day's toil, can see, handle and admire, the product of his effort. It is much more likely that he has tightened an endless succession of nuts on an endless procession of bolts on machines that rapidly disappear from view; or that she has filed a multitude of forms or letters whose meaning is completely unknown to her. There is very little in these situations to give satisfaction and a feeling of accomplishment. If life is to have meaning and interest and to provide a sense of fulfilment, it will not be achieved in these or similar tasks.

In addition to the shortened work week and the increased importance of leisure, we must consider the effects of urbanization. Fewer people than ever before live in rural areas where it is much easier to occupy one's hands and interests. More and more we collect in cities and dwell in cells of housing units where we are increasingly dependent upon our own resources to maintain satisfaction and interest.

Another problem which we face has to do with aging. The life expectancy has changed appreciably in our century. The average female in 1909 had a life expectancy of 56 years; by 1947 it was 66.5 years; in 1961 it was 70.8 years. The inevitable result is a steady rise in the percentage of our population who fall into the older age group. Like the increase in leisure time, this increase in life expectancy has produced a new problem. How do we keep this group of people in a state of excellent mental and physical health?

In our culture, careers are likely to be organized around certain typical social roles — as father or mother, husband or wife, employee, trade union member and the like. It is through discharge of the duties entailed in these roles that we acquire status in the eyes of our fellows, self-respect in our own and, in general, obtain some of the deepest satisfactions in life. As we grow older these roles become played out; the children leave home; the waning of our physical powers prevents participation in a wide range of social activities formerly available to us. Above all, for the majority of us,

old age sooner or later brings forcible retirement from work. It is this last which is usually the hardest to bear because our society is essentially work-oriented. Our success, prestige and achievement are intimately bound up with our ability to gain and hold a good job, to be industrious, and to earn good money. The sudden loss of these satisfactions, and even more, the loss of a sense of purpose, produces ill effects which are difficult to equate with good health.

We are not helped to grow old happily by the tremendous value which our culture attaches to youth. The advertising agencies, the standards of personal appearance and behavior, all rest on the assumption that it is the young who are the favored ones of this world. Thus age comes to represent only the loss of youth. The gains of advancing years, such as considered judgment and maturity, which can be bought at no lesser price, are correspondingly neglected.

Quite apart from the expanded goal of keeping people in a state of physical, mental and social health, we face new challenges in the management of our sick and injured. We, in the health fields, have not taken very seriously the management of a patient beyond that part of his illness which endangered his life or made him acutely uncomfortable. We have tended to lose interest in him as soon as his temperature fell to normal or his serious discomfort disappeared. We have taken little responsibility for accelerating his return to a productive and active life. On our continent, too, we have not been active in rehabilitating our injured and aged into industry. Increasingly, we are becoming aware of the fact that we have only been doing a part of our job. We must bring forces to bear on every patient as early in his illness as is possible to bring him back to a state of productivity. We still put too many patients into hospital; when in hospital, we immobilize them too much. Because of our approach toward their treatment we lengthen, rather than shorten the period in which they are unproductive. Before we can wisely apply the forces of rehabilitation we must master techniques and skills which we do not yet possess.

We must develop new skills, new understandings. We must pioneer public education in physical, social and mental health. We must prepare people for increased leisure and for their retirement years. We must not pamper and shield our handicapped, but rather give them an opportunity to achieve self-respect and satisfaction by becoming productive to the maximum of their ability.

To do these things, I would suggest that we must add new groups to the nurses and physicians who have been occupied in this field. We must lean much more heavily than we previously have on rehabilitation therapists — both physical and occupational therapists. We must rely much more than we have on the sociologist, the psychologist, the social worker. We must welcome these groups as full-fledged members of the health team with a great deal to contribute. We must be prepared to work more closely together than we have in the past, and not permit interdisciplinary barriers to be raised.

If we are going to achieve this end we must re-orient our educational practices. All of us come from such differing backgrounds of education, we are so compartmentalized and segregated during our training periods that for many of us it takes years to overcome the misunderstandings and even suspicions produced by our undergraduate experiences. Surely this must end. If we are to work as a team, we must be educated as a team. We must share experiences and get to know, respect and honor each other's contribution when we are undergraduates. I would like to think that in the years ahead we will see great health science centres develop in Canada in which all members of the health team will be trained — trained under the same teachers, working in the same environment, studying together, eating together, building up a recognition of what each group has to offer in the over-all field of health care.

This, I think, is one of the major challenges that faces our two professions. We have held centre stage in this exciting drama for a long time, but I do not believe that we can afford to continue to occupy that spot un-

shared. The degree to which we can gracefully share the spotlight with a variety of other groups, whose contribution is becoming indispensable to the welfare of our patients, will be a great measure of how our professions have matured over the years.

There are other changes which lie ahead. The organization of health care in this continent has — like Topsy — just growed. There has been a long-time exploration of the acceptable role of the nurse and of the doctor and, although the roles have changed with advances in health care, the image of what we are each expected to do has gradually crystallized. This same sort of exploration has taken place in other parts of the world and the findings are not necessarily the same. For example, in our country and on our continent, we insist that the physician accept the responsibility for many aspects of health care that are undertaken by nurses in other parts of the world. In Sweden, where the standards of health care are extremely high, there are many fewer doctors and many more nurses than there are in Canada. Nurses routinely do much of the home visiting and house calls that the physician undertakes in our country.

To date, we have lived entirely under a free-enterprise system of health care and there has been little self-examination of what has been produced. With health care becoming a government-supported service and with the value and the quality of our services coming under scrutiny, we face an entirely different situation.

I believe that anyone who has had an opportunity to study health plans in operation in various parts of the world must come to the conclusion that ours is a costly plan. We are insisting that very highly-trained people perform services which could be supplied as well or better by individuals with a less lengthy and less costly training. We may be able to continue to afford our present type of service but it would be my guess that forces will soon come into play which will insist that we obtain the maximum return on our health dollar, and if this happens, we will see a re-alignment of the duties of the nursing profession as well as the other members of the health team.

Coming!

IN

JANUARY 1965

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and

A NEW FORMAT FOR THE CANADIAN NURSE

A COUNSELING PROGRAM: LUXURY OR NECESSITY?

MATILDE YAP

Is there a need to establish and maintain a counseling program in a school of nursing?

Before one can really understand the importance of counseling as an integral part of the total educational program of any school, one has to know and understand the concepts and principles underlying counseling itself.

No valid system of education can be based upon the idea that what the child wants is always the best for him or that he wants everything he needs. Education has certain goals or objectives which have been determined by a developing and developed society. Modern society, with its increasing complexity and the resulting interdependence of all its parts, has created situations that are totally beyond the average individual to meet without help. This is the primary reason for the establishment of schools.

What Counseling Is

Counseling is one of the tools in the accomplishment of educational aims. It is the heart of a guidance program that involves certain essential elements: someone who has a personal problem to be solved — the counselee; someone who gives expert assistance — the counselor. It involves recognition or awareness by the counselee of a problem that calls for a solution; identification and understanding of the problem with help from the counselor as required; accumulation and interpretation of all related information by the counselee and the counselor; making a decision and planning ahead *or* gaining new insights and understanding. The counselor assists with the latter as required. When these elements are present, counseling takes place, no matter what the title may be of the person giving the counseling.

These essential parts of the procedure do not necessarily characterize its beginning, but there must be awareness of a problem before the counselee can be considered as an entity. Problems involved may be related to education, social adjustments, health, vocation and personal matters. For purposes of counseling, data must be accumulated and reviewed; information about opportunities and requirements must he available; working relations must be established between the counselor, other teaching staff and persons providing special services within the school and the community for referral purposes; records must be made of counseling interviews; continued contact must be maintained with the counselee in order to estimate the value of counseling and the extent of additional needed services.

All counseling has an effective element along with motivational, perceptive, and learning dimensions. The counseling situation provides an opportunity for the student to feel that someone is interested in him; it offers him the opportunity to recognize his goals and to verbalize the processes that resulted in their selection; it helps him to learn certain facts that are not effectively taught through personal interview. This kind of counseling need not be limited to the school, but like all kinds of education, it can enter into the community.

Briefly, counseling is a process in which the counselor assists the counselee to interpret facts relating to a choice, plan or adjustment that he must make. It is a face-to-face situa-

Miss Yap resides in Montreal.

tion in which by reason of his training, skill or the confidence vested in him, one person helps the second to face, perceive, clarify, solve and resolve adjustment problems. It is a client-centred relationship. The counselor's objective should be based on scientific rather than sentimental principles ; on the client's need rather than the counselor's need ; on the concept of the relative world in which we live rather than an absolute world ; on a strong belief in the strength and capacities of one's viewpoint.

Techniques

In the counseling relationship, the allegiance of the counselor is to the counselee. Certain approaches in individual adjustments are possible only as a result of counseling procedures. The counselee's assurance that her counselor regards her interests as of prime importance is vital. It is the same relationship that exists between a patient and his physician, a client and his lawyer. This factor is involved in the assignment of members of the staff or faculty as counselors because it is generally recognized that it is difficult for one who must act with authority in disciplinary matters to maintain status as a counselor. For this reason, it may be best not to assign regular counseling duties to administrative staff members unless the staffing pattern makes it unavoidable. Generally speaking, administrators do good counseling only when they are able to observe the basic principles on which it depends.

It has been stated that the counselor owes first loyalty to the counselee. Does this apply in all cases? What about the very young student who for some reason that certainly should be ascertained, has made a false entry on the patient's temperature chart? Is this an instance where first loyalty should be to the patient? Does it not call for disciplinary action? Such an act, by which the student endangers service to the patient mars the reputation of the hospital and reflects poorly on the profession. Admittedly, this is a serious problem, but the dangers of hasty disciplinary action or unsatisfactory solution are greater to the student, to the institution and to the profession. The student's professional future is at stake. The cause of the fault may lie in some lapse of training, supervision or administration that can only be overcome by a proper counseling approach.

In determining goals the professional counselor should think in terms of the of the counselee's satisfaction and not of her own. The goals of counseling do not include the concept that the counselor should help the counselee to become a passive, acceptable, agreeable fellow who resembles a vegetable much more than an independent human being. She should not persuade the counselee to change her decisions and choices in favor of those that are "right" but she should approach her with an open and understanding mind that respects the integrity of the counselee to the extent of believing that she has the right to make her own decisions and choices.

Counselors need to know the limitations as well as the possibilities of the non-directive technique. Rigidity in its use may cause as much resistance as the ineffective use of any other measure. Proper use increases the counselor's effectiveness in that she knows where she stands with the counselee. This is most likely to result if the counselor uses responses that are accepting and clarifying. Procedures that eliminate defensiveness on the part of the counselee and which make her feel that she is deeply understood, are most successful.

Who Should Counsel?

Variations in personalities, interests and experiences will make certain persons more able to counsel than others. The word "counselor" does not refer to the title of a position but to anyone who engages in counseling. Total counseling is not a one-person responsibility. While specific assignments are given to individual staff or faculty members, there is a need for an overall organized counseling program requiring cooperation on the part of all staff and faculty members. Personnel should be selected on the basis of desirable personal attributes as well as teaching skills. They should be people whom the students could feel free to approach for help in solving problems. This is particularly true of those who

are concerned with the educational program in any university school of nursing.

Counseling promotes profitable interaction between the learner and her environment. Counselors must always keep in mind and emphasize to students that learning takes place by the gradual acquisition of increased proficiency after repeated efforts.

Faculty members of university schools of nursing often feel inadequate or incompetent to counsel students, as indeed most expert counselors do at times, but they are unquestionably in a better position to be helpful than some of the persons to whom students turn when no other help is available. Counseling is a form of teaching. The individual is assisted to arrive at an insight into and understanding of her own problems, and to work towards a better balance between the demands of environment and the internal pressures of the individual. Obviously, this refers to those within the so-called "normal range" of individual adjustments. The fact that the faculty member recognizes her limitations in dealing with more extreme emotional problems is her safeguard. There still remains a wide range of counseling situations in which she has much to offer.

Value of a Counseling Service

One of the most unique contributions that counseling makes to the educational program, and that is sometimes difficult for school administrators and instructors to accept, is the opportunity that it gives to the student to develop effective techniques for solving her own problems. Counselors cannot force students to be counseled. This approach destroys the effect. A *conference* may be required but *counseling* cannot be compelled.

The role of the counselor in orientation should be considered, since it is part of the total program. Her constant contact with individual students and her non-authoritative relationship with them frequently results in her awareness of problems before they come to the attention of other personnel. Different medical lecturers, for instance, adhere to varying theories concerning diagnosis and treatment. Almost inevitably contradictory statements will be made. Students must be helped to realize that there are different points of view and that as nurses working with different physicians, they may be called upon to adjust their procedure of nursing care to conform to individual theories.

Students require orientation to the profession generally so that they know what to expect and how to cope with situations that may arise, especially in relation to clinical experience and their relationships with other students, graduate nurse staff, patients and the various categories of hospital personnel.

Conclusion

Counseling should be an integral part of the total educational program of any school of nursing in order to produce a group of well-prepared, personally adjusted and professionally competent nurses. It is not a luxury but a necessity. Sound help through counseling involves full recognition of the interrelationship of social factors, personality, and character. Resources within the school and the community favorable to the development of intellectual, social, and physical abilities should be investigated and utilized to provide for the diverse needs and capacities of a heterogeneous group of individuals.

Charcoal-broiled food is not harmful to man, says the secretary of the AMA Council on Foods and Nutrition.

This should quiet the fears of backyard chefs and patrons of charcoal-type steak houses who were alarmed by a recent report that said cancer-producing chemicals resulted from this type of cooking.

— *The Horner Newsletter*

No one has ever been able to change from one kind of life to one totally different without marked unrest. Adolescents have progressed from the state of "please help me" to "I can take care of myself." They need, now, to learn the third, the responsible stage: "Please let me help you." — *The Royal Bank of Canada Monthly Letter.*

IN A CAPSULE

THEY ELOQUENTLY STATE FLATLY . . .

In a recent issue of *Hospital Administration in Canada*, the editor comments: They [hospital administrators] have had a large measure of success in maintaining a steady rise in nurses' salaries during the past six years or more. The fact that by next year nurses' salaries in both Ontario and Quebec will be higher than in British Columbia, where nurses have bargained collectively for fifteen years, is eloquent proof not only that administrators have been successful negotiators, but also that they really care about whether their employees are getting a fair shake. One is naturally drawn to the observation that if and when nurses get collective bargaining, a very different role will suddenly be cast upon administrators. Instead of negotiating on behalf of nurses, they will be suddenly negotiating with them, which is to say against them. And when this time comes they will, for their own protection, turn the job over to highly skilled professional bargainers whose main concern will be with the technique of successful bargaining. No doubt the results will not all be bad from the nurses' point of view. *But neither are they likely to enjoy so many favours from a group that can plead their case so eloquently and so well* [italics ours].

In the same issue, *HAC* reports the reactions of a "number of administrators" to the new salary scales contained in the 1965 RNAO personnel policies:

* The $25 increase in the base rate asked for by the RNAO is *unlikely to be accepted*, though administrators in all parts of the province seem to be thinking in terms of another increase in the basic salary for general duty nurses next year. . . .

* The RNAO has dropped all scales for annual increments in favour of a straight 5% annual increment as merited, and calculated on the beginning salary in the nurse's category.

Hospital administrators state flatly that these open-ended increments are out.

RHEUMATIC FEVER

Nurses can make important contributions toward the rehabilitation of the child with rheumatic fever or rheumatic heart disease. They can advise both child and family regarding prevention of recurrence; they can help school teachers to understand what heart disease in childhood means; they can use school health services in finding and following cases; they can devise ways of keeping effective records and referral forms; they can work closely with community health and welfare agencies and professional personnel; they can keep current with the latest medical information; they can serve as links in the chain of events from the time of diagnosis until the child reaches maturity and assumes his rightful place as an individual, a family member, and a citizen in the community. — Dick, L. S. and M. D. Grant. The Nurse's Role in Rehabilitation of the Child with Rheumatic Fever. *Public Health Reports*, 79:533-536, June, 1964.

WHO KNOWS THE TRUTH?

Among the welter of complaints about patients "not being told," no one ever seems to question whether or not anyone in fact *does* know. The first or second-year student nurse almost certainly doesn't know; she hasn't the experience to make her own judgments and she is rarely in possession of all the revelant facts. The ward sister is, perhaps, a better guide; she has the advantage of experience and has had time and opportunity to discuss the patient with the medical staff — but most of the time it is the medical staff themselves who don't know the answers. Now this is no reflection upon the medical staff; it is merely to state that our knowledge of the workings (and still more the upsets) of the human body is very, very incomplete.

There are many patients lying at this moment in medical wards of hospitals who are, quiet frankly, "bags of mystery . . ." I submit that, half the time, patients are not "being told" because in many instances nobody knows. — Jottings by Gadfly. *Nursing Times*, 60:878, July 3, 1964.

MULTIPLE SCLEROSIS

MARILYNNE FISHER *and* JOYCE EINARSON

The patient starts to walk across the room. Halfway across, he spots a child's toy immediately in his path, yet is unable to step around it. He walks into the toy, stumbles over it. You ask him a question, unexpectedly. He doesn't answer and you think he's being obstinate and contrary. It's easy to jump to wrong conclusions unless you understand. This patient has multiple sclerosis.

Multiple sclerosis (MS) is a disease that attacks the protective covering (myelin sheath) of nerves throughout the central nervous system. The lesions appear mainly in the white matter of the brain and spinal cord, and consist of circumscribed patches or "plaques" of demyelination. This destruction of the myelin sheath causes interruption of nerve pathways; when a nerve impulse passes through a damaged part, the bodily functions which it controls may be disturbed or destroyed.

There is evidence of partial healing of the areas of degeneration, which accounts for the transitory nature of many early symptoms. The scarring that occurs at the site of the degenerative lesions gives the name sclerosis to the disease.*

The etiology of MS is unknown despite constant and continuous research. It is interesting to note that it is more prevalent in northern climates than in tropical countries and is slightly more common among females. It generally has its onset between the ages of 20-40 years — the period of one's life that is normally considered to be the most productive.

The disease is characterized by remissions and exacerbations. Some patients appear to live out an average life span while others may reach the terminal stage of their illness as early as five to ten years after the onset.†

Signs and symptoms vary according to the areas affected and the progression of the disease. Early symptoms are generally transitory. They may include visual disturbances, weakness, stiffness or numbness of a limb, or mild emotional disturbance — all evidence of scattered involvement of the nervous system. Later symptoms may include dysphagia, paraplegia, bowel and bladder dysfunction and severe muscle spasm and contractures.

There is no specific treatment for MS. Treatment and nursing care attempt to keep the patient comfortable, active, and independent for as long as possible.

Mr. Lee, aged 34, is married and has one child — a boy, aged seven. Before hospitalization, he worked as a service station attendant and was taking a night course in electronics.

His illness began three years ago when he first experienced an area of blindness in the left eye and, along with this apparently insignificant symptom, complained of feeling generally tired. Prior to this, he had had a severe attack of influenza, followed by sinusitis. At first, the physician believed the blind spot to be a result of optic nerve damage caused by infection. No visual difficulties were noted while the patient was relaxed and not straining his eyes to look at an object or print.

Later, the patient noted twitching of both eyes and decreased visual acuity in the right eye. He found himself losing his sense of equilibrium; each time he turned quickly he became dizzy and nauseated. Often he would vomit at this time. He developed a staggering gait and pronounced incoordination; grasping ability soon disappeared; his legs gradually became much weaker, eventually resulting in partial, then complete paralysis of arms and legs. As these symptoms developed, it became evident that he had multiple sclerosis with spinal cord and

Miss Fisher and Miss Einarson were students at the Saskatoon City Hospital School of Nursing, Saskatoon, Sask., when they prepared this article.

* K. Shafer, et al, *Medical-Surgical Nursing*, St. Louis, C. V. Mosby Co., 1961, p. 743.

† Paul Beeson and W. McDermott, *Cecil-Loeb Textbook of Medicine*, Phila., W. B. Saunders Co., 1963, p. 1671.

cerebral manifestations due to the demyelinating process.

Bladder retention and urinary stasis necessitated surgical intervention to sever the nerves to the bladder. This resulted in an atonic, neurogenic bladder. Personality changes of slowness and indifference were noted and the patient was subject to periods of severe depression. In the space of two years he was limited to the use of a wheelchair. He soon lost muscle power to maintain erect posture in the wheelchair and hence was committed to complete bed rest.

This patient is an example of the rapidly progressive type of MS. Unlike most patients with the disease, he had few, if any, remissions during the three-year period.

Mr. Lee could have been sent home at this point if full-time nursing care had been available. His wife was unable to provide this since, in addition to caring for their young son, she was teaching school and attempting to complete her degree in education.

Home Environment

The family of an MS patient should be given a simple, but clear explanation of the pathological as well as the psychological changes in the patient. If home care is provided, family members should understand that a quiet, cheerful environment is essential to the patient's well-being. He should not be rushed or expected to respond quickly, either mentally or physically. If he is ambulatory, floors should be kept clear — scatter rugs, unnecessary furniture should be removed. Hazards such as wet floors, mops, brooms, pails, electric light cords and children's toys must be kept out of the way.

A common late symptom is spastic paraplegia and, as spasticity of the legs increases, the patient develops a stiff-legged gait which makes walking difficult. Handrails between strategic points in the home will help him remain ambulatory as long as possible. Stair climbing is to be avoided. When bathroom facilities can be provided, the patient's bedroom should be on the ground floor.

When walking becomes extremely difficult or impossible, a wheelchair should be provided. Precautions must be taken to avoid injury in transferring the patient from wheelchair to bed. Both the wheelchair and the bed should be secured against rolling. A ramp, easily built, will make getting in and out of the house a simple operation. All the doorways should be wide enough to allow easy passage from room to room. If items which are used frequently are placed on low shelves, the patient will be less dependent on others.

Since association with others is good for physical and mental health, the patient with multiple sclerosis must be helped to remain an active, participating member of his family and his community for as long as possible. He should be encouraged to develop hobbies and interests to replace former activities.

The National Multiple Sclerosis Society

This is an organization that has enlisted the active interest of a large group of physicians, neurologists and other scientists. It initiates, promotes and supports basic research directed toward finding the cause and a means of controlling and treating multiple sclerosis. It informs people who have the disease and their relatives and friends of the known facts regarding it and the latest developments for its management. It informs the general public as to the nature and prevalence of multiple sclerosis and the needs of those who suffer from it. It extends direct aid to people who have the disease through active chapters of the Society. Nurses should be familiar with this Society and its objectives so that they can refer the patients and their families to it.

Conclusion

Since multiple sclerosis is a disease that is usually irregularly progressive, the nursing needs of the patient may become increasingly complex. By applying intelligent understanding, wise counsel and thoughtful care, the nurse can contribute immeasurably to the patient's happiness and usefulness. She can help the family accept the illness, thereby allowing the patient to carry on with a minimum of discomfort and dependence.

All in a Day

P. E. (AUSTIN) CRUICKSHANK

This Christmas Day experience, written by a student who graduated twelve years ago, will poignantly remind many of us of our own encounters with reality in the hospital ward.

It was 7:30 a.m. on Christmas Day — my first Christmas in a large training hospital. I walked into the gaily decorated ward and hesitated before the dark green screens that surrounded the small patient in the corner bed. My assignment was to "special" this child, which meant that I would remain with him continually throughout the day, observing his condition and administering any necessary treatment. This was the first time that I had been permitted to perform such a responsible task, and I felt very apprehensive.

As I opened the screen, the night nurse rose from a chair beside the bed; she handed me the child's chart, explained his condition and treatment in a low tone, and left quietly. I turned my eyes to the bed which appeared exceptionally large and white, accentuating the smallness of the figure in it. A large parcel, gaily wrapped in Christmas paper, lay unopened on the bottom of the bed. The child was lying flat and still. His face was badly bruised, and a crop of fair, ruffled curls peeped above the bandage surrounding his forehead. His left arm lay on a splint that immobilized the limb; blood dripped steadily into a vein through the rubber tubing connected to the bottle of blood elevated on a stand beside the bed.

I felt the pulse at his wrist; the beat under my fingers was flickering feebly and rapidly. The boy opened one large blue eye — the other eyelid was too swollen to permit movement. A cheeky little grin spread over his face.

"Hello, Jim," I said. "You'll soon be feeling fine now."

The grin broadened slightly before the lid closed over the blue eye and Jim drifted back into a semi-comatose sleep.

A small, slim woman was sitting quietly beside the bed. Her shoulders were slightly bowed and her face drawn and pale. I could feel her anxious eyes watching me, as I wiped the beads of perspiration from Jim's face.

"How is he, nurse? How's my boy?" she whispered.

"He's about the same, Mrs. Peters," I replied.

What words of mine could comfort this poor mother? What could I say to help her?

Jim's breathing became more labored, and a bluish appearance crept over his face. I turned on the cylinder beside the bed and administered oxygen to him through a small nasal catheter. Gradually his color improved and his breathing became more natural. The minutes ticked by unnoticed, for somehow time was unimportant. Everything apart from Jim was unimportant. This little life had to live.

I could hear the laughter of the patients in the nearby ward as they joined in the Christmas festivities. The lovely words of a well-known carol sounded in the distance.

Away in a manger,
No crib for a bed,
The Little Lord Jesus
Lay down His Sweet Head.

Jim's mother moved her eyes from her son to me.

"His father is a wonderful man. He is at home looking after our other three children. I hope poor Joan is all right. She is only seven, and last evening she witnessed the lorry running into Jim," she said.

My thoughts turned to the father making merry at home for the sake of his children, while his heart was here with his wife and sick child; and of the girl who had witnessed the accident, the image of which was probably indelibly stamped upon her memory. I felt admiration surging within me as I realized the great love, thought and consideration given to their children by this couple. Christmas had always been a rather selfish time for me, spent with my own

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Mrs. Cruickshank, a graduate of the Royal Salop Infirmary, Shrewsbury, England, came to Canada in 1958. She and her husband and five children now reside in Toronto, Ont.

family, enjoying the seasonal good food, games and excitement; I had barely given a thought to those not as fortunate as I.

The ward sister appeared and gave a cup of tea to Jim's mother. The blood transfusion bottle was almost empty. Sister changed it swiftly for a vacolitre of dextrose which maintained the steady drip into the small vein.

Jim began to get restless, and the rhythm of his breathing became irregular. One minute he would be breathing noisily and deeply; then, gradually, the volume faded until it appeared he was not breathing at all. Then it would recommence quietly, gradually rising to a crescendo thus commencing the cycle again. I had learned about this type of breathing in the lecture room. It was known as Cheyne-Stokes breathing, and was not a good sign. I told Sister. She gave Jim an injection, and, feeling his pulse, turned gently to his mother, saying, "I am afraid he is not quite as well, my dear."

There seemed to be something in Sister which gave her the ability to help this poor mother in her grief; her words were few, but her entire being appeared to be giving sympathy and understanding.

A short time later, a nurse came in to take care of Jim while I went to lunch. As I walked into the dining room, two of my friends shouted, "Happy Christmas, Austin! We are throwing a party tonight. Will you come?"

I saw Sister watching me as I shook my head. "No thanks," I replied.

I looked at the food on the plate before me. I was not hungry. How could I eat while I thought of Jim and his mother? I felt confused. I couldn't understand the justice of this suffering. I needed to think. I rose from the table and hurried from the room.

I hesitated in the corridor. Sister caught up with me. Her face was serious, but she had a kind expression in her eyes as she spoke.

Nurse, you are experiencing something entirely foreign to you. You are seeing one of God's children being called to Him. You are witnessing the complete, selfless love of this mother for her entire family. But, just as this woman is coping with her grief, with God's help, *you* must cope with your nursing. No textbook can help you here; you can learn this only by experience and thought. You must always remember to consider all the members of our hospital family. First, there are all the other patients, in whom it is your duty to inspire confidence, and with whom you must always be cheerful and composed, no matter what your personal feelings are. Second, you must receive the friendship offered to you by your colleagues, and, third, nurse, you must eat to maintain the physical ability to do the work you have chosen.

I looked at Sister — tall and quiet, efficient and kind, observant and helpful — and realized how much she was able to give to her profession. I felt ashamed. For the first time, I realized that nursing did not merely consist of making beds, taking temperatures and the many other routine jobs; that it required something far greater than simply physical effort.

When I returned to Jim, his mother was holding his small hand. I felt his wrist; it was very cold and the pulse was almost imperceptible. His respirations were quiet and shallow, and the silence in the room was cut only by the faint burr of voices from the next ward. Sister gave Jim another injection; the fluttering pulse improved slightly in volume, only to fade again rapidly.

It was 3:30 p.m. when Jim stopped breathing. Sister gently led his mother from the bedside.

"My boy didn't suffer much, did he?" asked Jim's mother quietly.

"He felt very little pain," replied Sister. She asked Jim's mother whether she would like her husband to be contacted by telephone.

"No — no, please don't do that. It would be such a terrible shock to him. I'll tell him — he'll need me. We mustn't spoil the children's Christmas. I'll tell them tomorrow that Jim has gone to live with Jesus. They will understand that, with the memory of the Nativity so vivid in our minds now."

I took her down the stairs and saw her into a taxi.

"Goodbye, nurse, and thank you," she said.

I slowly returned to the ward.

"I want you to help serve tea to the patients and their visitors, please, nurse," said Sister. I wheeled the gaily decorated food trolley into the ward.

"Hello! Happy Christmas!" shouted the patients. "Come and pull this cracker with me, nurse," said one.

I put a silly paper hat on, over my cap.

"Happy Christmas, everybody!" I replied.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Partners in medicine

The following is reprinted in full from the editorial page of the *Toronto Globe & Mail:*

One of Canada's most distinguished nurses has produced a book which could and should have a far-reaching effect on the nursing profession and the quality of service it can offer to the public. The book is actually a thesis, written by Dr. Helen K. Mussallem for her doctoral degree in education at Columbia University.

In 1960, Dr. Mussallem examined the situation and problems of nurses across the country on behalf of the Canadian Nurses' Association, and produce a report on nursing education. Her present thesis, *A Path to Quality*, moves forward with the subject. Its theme is direct: take the education of nurses out of the hands of hospitals and place it where it belongs — under the educational authorities.

Dr. Mussallem points out that a hospital tries to combine two functions — the care of the sick and the training of nurses. Whenever the two purposes of the hospital are in conflict, needs of the nursing services take precedence over educational needs of the students. The hospital-controlled program does not provide opportunity for development of a broad educational program in line with the best in education thoughts.

"Representative opinions from 100 experts in the fields of health and education showed an overwhelming majority in favor of placing nurse preparation under the educational system," Dr. Mussallem asserts. The one dissenting voice was that of hospital associations, and it could here be pointed out, though Dr. Mussallem does not, that hospital associations have a prejudiced reason for hanging on to the training of the nurse — she provides cheap labor.

"Whether or not nurse preparation should be placed under the general educational system can no longer be a point of debate," she adds. "It is possible and can be done. And if the nursing profession does not move it may be done by another group."

Dr. Mussallem's reasons for taking the trainee nurse away from the hospital and giving her to the university are unassailable — the change would give us better qualified nurses, and give them to us more quickly. But there is another reason why the change should take place.

The hospital system of training nurses is closely akin to the army system of training soldiers. It segregates the trainee from the rest of the community; it subjects her to what is virtually a military discipline which places greater value on unquestioning obedience than on the questioning search for knowledge; it deprives her of some of her civil rights — she must submit to curfews, to a considerable control of her leisure time, even to dictates about her personal grooming. Not only her uniforms but the makeup she wears and the hair styles she may adopt are determined, not by her but by her superiors.

Many hospitals have recognized that this quasi-military system is an anachronism in this century of individual freedoms and have made determined efforts to soften its more rigid effects. But to a greater or lesser extent it still functions in most hospitals.

The unfortunate result is that it produces nurses who are discontented with their lot but incapable of correcting it. A young woman cannot submit to such disciplines for three years without losing some of her sense of individual freedom, especially in relation to the hospitals which have indoctrinated her.

The average nurse is as incapable of rebellion as the average soldier is incapable of mutiny. She has not been able, either as an individual or through an organization, to

demand her right to better salaries, better working conditions, reasonable working shifts. She has not even been able to insist on that most basic of rights — the right to be treated as a reasonable, responsible adult in a free society.

Yet, as a human being in that free society, she cannot fail to resent the strictures which apply to her and to nobody else. But she can escape them only by escaping the hospital. This basic search for freedom, quite as much as low salaries and poor working conditions, has driven thousands of nurses out of the hospitals, and even out of the nursing profession.

Nurses who acquired their education under an educational authority would be far different creatures. They would go into hospitals as other civilians go to new jobs, prepared to submit to reasonable direction but also prepared to insist on a fair deal, and free enough to make the authorities yield it. They would become partners in the medical team instead of its disciplined flunkies.

Million Dollar School of Nursing for Manitoba

Building is underway on a new $1,000,000 school of nursing and residence at the Brandon General Hospital. The cost of the school will be borne by federal, provincial and municipal taxpayers, and will accommodate 160 nurses, twice the school's present capacity. The opening is scheduled for next summer.

The new school and residence, which will be connected to the hospital by a tunnel, will contain classrooms, demonstration rooms, laboratories, conference rooms and office space for faculty members. Definite plans have not been made about the old building, built in 1921, but it is thought it might be used for retarded adults and children.

New Program Open to Graduate Nurses

The Department of Nurse Education of New York University's School of Education has instituted a new graduate nursing curriculum in child psychiatry. The two-year study program, which leads to a master of arts degree, is open to graduate nurses who hold a baccalaureate degree and who wish to specialize in the care and treatment of emotionally ill children. DR. CLAIRE FAGIN is director of the new curriculum.

Former Dean to Lecture at New School

EDITH M. MCDOWELL, former dean of the school of nursing of the University of Western Ontario, will be a part-time lecturer at the graduate school of hospital administration to be established at the University of Ottawa.

The school, organized at the request of the Catholic Hospital Association of Canada, will be the third in Canada. Others are at the University of Toronto and the University of Montreal. On the campus the school will have equal status with the existing professional schools of nursing, psychology and education, physical education and recreation, social welfare and the library school.

Receives Fellowship Award

MRS. A. ISOBEL MACLEOD (right), president of the Canadian Nurses' Association, presents the W. B. Saunders Nursing Fellowship award to JEAN CUMMINS of Calgary. Miss Cummins,

a graduate of Holy Cross Hospital school of nursing in Calgary and later a member of the staff of the Calgary General Hospital, is enrolled at McGill University to complete her bachelor of nursing degree. The presentation took place at the Montreal General Hospital, where Mrs. MacLeod is director of nursing. DR. HELEN K. MUSSALLEM, executive director of the CNA, looks on.

Newfoundland Chapter Establishes Scholarship

The Bell Island chapter of the ARNN has established a scholarship valued at $150 for girls, graduating from Bell Island schools, who are in-

terested in becoming nurses. Applicants must have matriculation standing but marks will not necessarily be the deciding factor. The scholarship will be awarded to the most deserving student.

Nursing Service Study

Ten representatives from all fields of nursing met in Ottawa recently for a four-day review and discussion of the reports of the findings of the twelve hospitals that participated in the Project for the Evaluation of the Quality of Nursing Service in Canada.

During this final phase of the project, headed by F. LILLIAN CAMPION of the CNA, the panel determined if the quality of nursing service met the established criteria and identified areas of strengths and weaknesses to be incorporated in the director's report to the CNA.

Members of the Panel of Review were: Trenna Hunter, director of public health nursing with Greater Vancouver Metropolitan Health Service; Edith M. Chapman, director of nursing, Sudbury Memorial Hospital; Joan M. Gilchrist, director of nursing, Jewish General Hospital of Montreal; Sister Mary Irene, director of nursing, Charlottetown Hospital; Edith Kemp, director of nursing, Provincial Mental Hospital, Ponoka, Alberta; Kathleen King, assistant professor, University of Toronto; Margaret McLean, nursing consultant with the Department of National Health & Welfare; Sister Mary Thille, Hôpital Saint-Jean; Margaret Wheeler, Division of Industrial Hygiene, Ministry of Health, Montreal; and Mrs. Katherine Wright, director of nursing, Moncton Hospital.

Independent School Opens in Ontario

The Hamilton and District School of Nursing, financed by the Hamilton Health Association, admitted its first class of students the end of September. The course of the new independent school is a two-year program leading to Ontario registered nurse examinations. Its students range in age between 18 and 40. Much of the teaching is in the form of laboratories, seminars, conferences, out-of-class papers and projects, in addition to field experience and practice. A considerable amount of time is allowed for independent study. Clinical experience is taken at hospitals in Hamilton and district.

Students particularly interested in certain aspects of the course will be encouraged to study these areas in greater depth than may be needed to meet the minimum of required knowledge — providing they make satisfactory progress in all other areas.

Grade 13 is a requirement for admittance to the school.

Invitation to Norway

The Norwegian Nurses' Association has invited members of the CNA to visit Norway in connection with their participation in the ICN Congress in Frankfurt next June.

Miss HETTY HENRICHSEN, general secretary, points out that study programs can be arranged in administration, education, general hospital nursing, geriatrics and care of the chronic sick, pediatrics, psychiatrics, public health and child welfare, and occupational therapy and rehabilitation.

Interested nurses should advise the Norwegian Nurses' Association, Universitetsgaten 12, Oslo 1, not later than January 31, 1965 giving the following information:

Name and address
Position held
Field of interest
Time of study (date of arrival and departure)
Address in Norway

FILM AVAILABLE

"Diabetes — "What You Don't Know *Can* Hurt You" is the name of a new 16-mm., 27-minute, color film now available for showings to the medical and nursing professions, diabetic clinics, etc.

The film discusses, in non-technical language, the body processes involved in diabetes and the methods of diagnosis and control of the disease. It covers all areas of diabetic management, including insulin therapy, tablet therapy, diet, care of equipment, urine testing and complications of diabetes. The film can be borrowed from:

The Professional Relations Manager,
Ames Company of Canada, Ltd.,
1131 Bloor St. West., Toronto, Ont.

A STATEMENT TO THE ROYAL COMMISSION ON BILINGUALISM AND BICULTURALISM

The Canadian Nurses' Association, L'Association des Infirmières Canadiennes, wishes to express its appreciation to the Royal Commission on Bilingualism and Biculturalism for this opportunity to present a statement portraying the unique nature of its organization and its views on cultural relationships.

The Canadian Nurses' Association with a membership of 77,618 is a federation of the ten provincial registered nurses' associations. It was formed in 1908 as an affiliation of existing nursing organizations in Canada and was incorporated in 1947. The Association's original purpose was to provide a link with the International Council of Nurses, an organization with which Canadian nurses have been associated since 1899.

Through the evolution of time and experience, the primary function of the Canadian Nurses' Association has come to be a fostering of high standards of nursing practice in Canada to the end that the highest possible level of health may be achieved by the people. The promotion of maximum health is the basis of the profession's concept of nursing care.

Membership in the Canadian Nurses' Association is obtained through membership in one of the provincial nurses' associations, each of which is authorized by provincial legislation to grant registration.

A registered nurse is represented in local and provincial matters by her provincial association; in national and international affairs by the Canadian Nurses' Association.

The Canadian Nurses' Association is a bilingual organization, in name and in operation. Its official journal *The Canadian Nurse* as well as other pamphlets and informational materials are published in English and in French. For many years, simultaneous translation services have been used in its general meetings for the benefit of its large membership of English and French nurses.

Historically, since 1639, when three French Augustinian nuns founded the first Canadian hospital, *Hôtel-Dieu de Québec*, differences of language, culture, religion or race have not deterred those who have ministered to the health and sickness needs of Canadians. Since its earliest beginnings in this country, nursing has been a multicultural activity.

Members of the Canadian Nurses' Association come from many races, religions and cultural inheritances. They enjoy freedom of movement in employment from province to province and from country to country. Similarly, qualified nurses from other countries assimilate easily into the nursing force of hospitals and health agencies in this country, assuming increasing responsibilities as their fluency in the language improves.

Outside the province of Quebec, English is the working language of most hospitals and health agencies in Canada. Many of these are bilingual and serve mixed populations. Hospitals serve all ethnic groups in their respective communities. Nursing in Canada is the better for the heterogeneity of cultures within its ranks. Differences of language, race and color are submerged by the commonalty of purpose and of organization.

A profession is always concerned with the improvement of the services given by its members. The Canadian Nurses' Association recognizes the necessity for nurses of the future, and indeed for all Canadians, to have a wider cultural preparation for life than most have possessed in the past. While many improvements in nursing service and nursing education are desired it would be difficult to relate them to linguistic factors. But certainly the quality of both nursing education and service would be enriched by changed attitudes of society toward:

1. Broad patterns of general education in a cultural climate fostered by both French and English segments of our society which engenders respect, mutual understanding and peaceful relationships.

2. New patterns of administration and support for nursing education.

It has been said that a situation in which two groups work autonomously and independently in the same general area has within it the seeds of confusion and controversy. Happily, the inter-related interests of French and English nursing services, where they exist side by side, are such that consultation limits confusion and consideration replaces controversy.

The Canadian Nurses' Association has adopted the Code of Ethics of the International Council of Nurses which states,

> Service to mankind is the primary function of nurses and the reason for the existence of the nursing profession. Need for nursing service is universal. Professional nursing service is therefore unrestricted by considerations of nationality, race, creed, color, politics or social status.
>
> Inherent in the code is the fundamental concept that the nurse believes in the essential freedoms of mankind and in the preservation of human life.

The profound influence of this ethic on nursing and nurses in Canada throughout the years has been demonstrated by the participation of nurses, both French and English, in:

— Mission work in the Canadian north and far away lands;
— Disaster areas served by The Canadian Red Cross Society;
— Services and projects of The World Health Organization, Colombo Plan, Canadian University Service Overseas, etc.;
— When called upon, Canadian nurses have served in theatres of war, at home and abroad.

To some degree, unilingualism may have been a limiting factor in these nursing activities but it has never been a deterrent. Bilingualism or multilingualism is, and will always be, a talisman to ever-widening opportunities for national and international service.

By virtue of the methods used and adaptations made by the Canadian Nurses' Association, the needs and interests of both French and English members have been met harmoniously and with mutual benefit to all.

Canadian nursing services throughout the centuries have been devoted to the care of men of all cultures and testify that the needs of people can be met without consideration of nationality, race, creed or color, when knowledge and skill are applied in the spirit of deep humanistic concern.

Believing in the universal freedoms, the Canadian Nurses' Association holds the view that Canadians should have freedom of choice in their basic education and preparation for life to the greatest degree possible without threat or danger to a united Canada. Grateful that the all-pervading purpose of nursing has not been divided by cultural differences, the Canadian Nurses' Association is concerned and cherishes the hope that all Canadians will have the opportunity to acquire and to possess a rich multi-cultural endowment of skill and understanding.

Mrs. A. Isobel MacLeod, R.N., M.A.,
President,
Canadian Nurses' Association

Helen K. Mussallem, R.N., M.A., Ed.D.
Executive Director,
Canadian Nurses' Association

ICN POSITION OPEN

Applications are invited for the position of Editor of the *International Nursing Review* which includes direction of the ICN Publications and Public Relations Department. Applicants must be nurses and members of their National Nurses' Association, with wide clinical experience, also editorial and magazine production experience, preferably with a national nursing journal. Fluency in English is essential, with good knowledge of a second European language, preferably French.

The position involves the preparation and production of material for publication in four languages as well as the promotion of public relations activities sponsored by Headquarters. A knowledge of the techniques of communication is desirable. The possibility of a transfer of ICN Headquarters to Geneva, Switzerland, should be taken into consideration by the applicant.

Application forms and further particulars may be obtained by writing to the General Secretary at ICN Headquarters, 1 Dean Trench Street, Westminster, London, S.W.1, England. Applications should be sent in duplicate, addressed to the president, Mademoiselle Alice Clamageran at ICN Headquarters, to be received not later than February 1, 1965.

Nursing Profiles

Margaret Emily Steed has been appointed nursing secretary with the Canadian Nurses' Association. She will asume responsibility for the nursing service and educational programs of the association and will assist with the planning, organization and operation of the international nurse visitor program. In this role she will give counsel and assistance to provincial associations regarding trends and developments in nursing and will cooperate with all countries in providing study and observation tours in Canada.

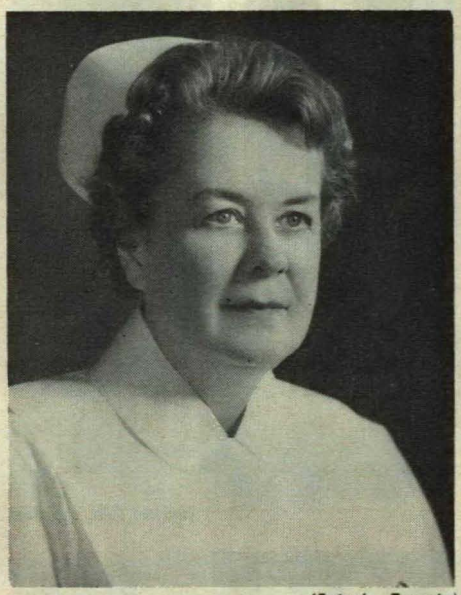
(Paul Horsdal, Ottawa)

MARGARET STEED

A graduate of the Toronto Western Hospital School of Nursing, Miss Steed holds a bachelor of nursing degree from McGill University and a master of arts degree from Columbia University. Her nursing career began at the Toronto Western Hospital and includes posts with the Canadian Army Medical Corps, the Kitchener-Waterloo Hospital and the South Waterloo Memorial Hospital.

Miss Steed has served on both local and provincial RNAO committees. In her leisure time she enjoys art and music.

E. Dorothy Arnot has been appointed director of nursing at The Wellesley Hospital, Toronto.



(Eaton's, Toronto)

DOROTHY ARNOT

The new director is a graduate of the Macdonald Institute, Ontario Agricultural College, Guelph, and the school of nursing, The Wellesley Hospital. In 1940, she joined the staff of her home hospital as assistant head nurse, a year later becoming head nurse. In 1947, she was appointed assistant director of nursing. On leave of absence in 1950, she took a postgraduate course at McGill University in administration in schools of nursing.

Miss Arnot is active in professional affairs. She has served on the RNAO executive, and as a member of both the registration and program committees. In her off-duty time, she enjoys music, sewing, reading and traveling.

For the past 43 years, the name of **Elsie K. Jones** has been associated with The Wellesley Hospital, Toronto. Last July, Miss Jones retired as director of nursing, a position she has held since 1937.

Miss Jones graduated from The Wellesley Hospital in 1921, eventually became assistant director and then director of nursing. The hospital she first knew has changed considerably in the intervening years and, when current construction is completed, will be a 600-bed institution.

(Le Roy Toll, Toronto)

ELSIE JONES

The Wellesley Alumnae Association has established a scholarship in Miss Jones' name and a trip to Bermuda was their farewell gift to her. Her portrait by Kenneth Forbes, which hangs in the residence, was the tribute of the student body.

Miss Jones, who was married in August, plans to live near Thornhill, Ontario, where she has a 10-room house and two acres of land. She says that she will now have time to do things she has always wanted do to — garden and fish.

Miss Jones' concern for high quality nursing care and her interest in students and staff will long be remembered at The Wellesley Hospital. We extend congratulations for an outstanding professional career and best wishes for the future — and good fishing!

Shirley L. Bates has been appointed lecturer at McMaster University School of Nursing, Hamilton.

Miss Bates graduated from the Hamilton General Hospital in 1949 and obtained her bachelor of science in nursing degree at the University of Western Ontario this year. Her professional experience includes teaching positions at the Victoria Hospital and the War Memorial Children's Hospital, London, Ontario, and Woodstock General Hospital, Ontario. For two years she was orientation supervisor at the Victoria Hospital.

(James C. Fish, Hamilton)

SHIRLEY BATES

Sister Noémi de Montfort, director of internal management, Hôpital Sainte-Justine, Montreal, has been elected to the newly-created Council of Regents of the Amer-

SISTER NOÉMI DE MONTFORT

ican College of Hospital Administrators, a professional society comprised of over 5,700 hospital administrators in the U.S.A. and Canada.

Sister received her nursing education at the University of Montreal and served, for a time, as a teacher at Our Lady of Sacred Heart Academy, Dorval, Quebec, and as assistant administrator of the Hôpital Sainte-Justine. She has been in her present position since 1960. In addition, she serves on the board of governors of the Quebec Hospital Association.

NAMES IN THE NEWS

Two Montreal nurses, **Céline Bourgeois** and **Phoebe Stanley**, have been granted scholarships from the Association of Nurses of the Province of Quebec for postgraduate study. Miss Bourgeois is a graduate of Hôtel Dieu of Montreal where she was supervisor of the central sterile supply unit and of a unit in the operating room. Miss Bourgeois hopes to complete her degree in nursing science from Institut Marguerite d'Youville.

Miss Stanley, a graduate from Women's College Hospital, Toronto, has been supervisor of the operating room, Montreal Neurological Hospital, for several years. She will attend McGill University to study for her bachelor of nursing degree . . . . **Florence McDonald**, formerly educational director, school of nursing, Edmonton General Hospital and instructor of the Namazee School of Nursing of Shiraz, Iran, has joined WHO. She will be working on a nursing education project in Damacus . . . . **Mary B. Lester** has been appointed chief of the Public Health Nursing Branch, Division of Nursing, U.S. Dept. of Health, Education, and Welfare. She succeeds **Dr. Marion Ferguson** who is now deputy chief of the Division . . . . **Ruth L. Johnson** has been appointed chief of the Hospital Nursing Branch, Division of Nursing, U.S. Public Health Service, Dept. of Health Education and Welfare.

The World Health Organization has onnounced the appointment of two new staff members from Canada: **Lorraine Lecompte**, who has been assigned to Dakar, Senegal and **Dorothy Knight**, whose assignment is with WHO-assisted TB Control Campaign in Basutoland. Before joining WHO, Miss Lecompte was senior nursing counsellor, Occupational Health Service, Dept. of National Health and Welfare, Ottawa. In Dakar, she will assist in public health nursing education programs. Miss Knight, before her WHO appointment, was on the staff of public health nursing services in the Health Unit, Timmins, Ontario . . . **Sister Catherine Gerard**, administrator, Halifax Infirmary, Nova Scotia, was recently elected to the newly-created Council of Regents of the American College of Hospital Arministrators, a professional society comprised of over 5,700 hospital administrators in the United States and Canada . . . An original letter written by Florence Nightingale from Crimea in 1856 was presented to **Beatrice Carter**, superintendent of nurses, at the official opening of the new Orthopaedic and Arthritic Hospital in Toronto.

MR. E. PROVAN *presents Nightingale letter to* MRS. B. CARTER.

NURSING LITERATURE INDEX

The need for a comprehensive index to nursing periodical literature, to serve nurses, educators, and researchers has long been recognized . . . . The recent development of MEDLARS (Medical Literature Analysis and Retrieval System) will enable The American Journal of Nursing Company to plan cooperatively with the National Library of Medicine toward the possibility of a published index to all nursing periodical literature. The American Nurses' Foundation will conduct a pilot study to determine precisely the scope and content of such an index. Funds for this study will be provided by an AJN Company grant to the Foundation. — *Nursing Outlook*, 12:4, June, 1964.

In Memoriam

Mary Ellen (Chiasson) Allard '38, Hôtel Dieu of St. Joseph, Campbellton, N.B.

Laura Jeanne (Maunder) Brayne '15, McKellar General Hospital, Fort William, Ont.

Margaret Frances Bushell '55, **Anna Evelyne Howard** '05, **Mary Louise (Newton) Hugessen** '44, **Dora (Greenwell) MacKinnon** '35, Montreal General Hospital.

Phyllis (Durden) Cattley '26, St. Thomas's Hospital, London, Eng.

D. Mildred (Outhouse) Griffin '30, Saint John General Hospital, N.B.

Mary J. (Pinder) Hiemstra '20, Victoria Union Hospital, Prince Albert, Sask.

Mary Elizabeth (Meldrum) Hollingsworth '09, Kingston General Hospital, Ont.

Atala M. Lacoursière '28, Hôpital Sainte-Justine pour les Enfants, Montreal.

Ruby Doreen (Cook) Laporte '47, Winnipeg General Hospital, Man.

Constance Alberta (Hicks) Lang '27, Mental Hospital, Brandon, Man.

Janet Isabel (Cameron) MacNeil '33, Salem Hospital, Mass.

Gertrude Evelyn (Sharpe) Menzies '37, Miramichi Hospital, Newcastle, N.B.

Henrietta Jane (Buchanan) Robertson '17, Sherbrooke Hospital, Sherbrooke, Que.

Myrtle Rose '43, Reddy Memorial Hospital, Montreal.

Jean (Sharpe) Scattergood '31, Public General Hospital, Chatham, Ont.

Sister Mary David Slattery, Hamilton Hospital, North Sydney, N.S.

Sister Mary Theodore '17, St. Boniface Hospital, Man.

Sister St. Joseph, Jeanne Mance School of Nursing, Windsor, Ont.

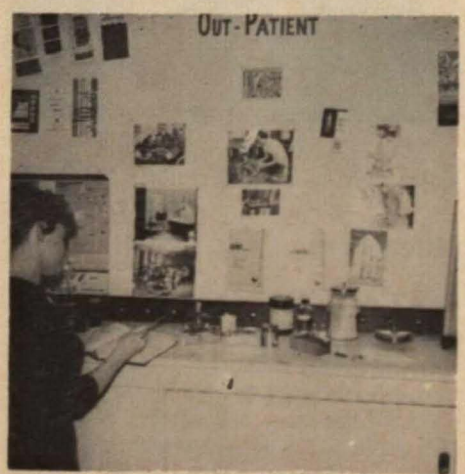
Ruth Jean (Orr) Watkins '32, Vancouver General Hospital, B.C.

NURSING CAREER DAY

The Kenora-Keewatin Chapter, RNAO, recently held a successful "Nursing Career Day" for local high school students and their parents.

The chapter president, Joanne Horan, reports that the first step was to form a "recruitment committee" to outline the program. The committee, chaired by Miss M. Castonguay, met several times and agreed that the display should be held in the local health unit building. Exhibits explaining the nurse's role in psychiatry, pediatrics, medicine and surgery, maternity, community health, etc., were set up with chapter members in attendance at each booth. A film, "A Day in the Life of the Student Nurse" was shown continuously during one of the career days.

The response of the students and parents was overwhelming. Altogether, 110 students and 29 adults visited the exhibits; 150 students took advantage of the tours held at the Kenora General Hospital and St. Joseph's Hospital.



Learning about "O.P.D."

Pediatric corner

About Books

Human Relations in Nursing by Wayland J. Hayes, Ph.D. and Rena Gazaway, R.N., Ph.D. 418 pages. W. B. Saunders Co., Phila. Ed. 3. 1964.
Reviewed by Mrs. Phyllis Dahlstrom, Assistant Director of Nursing Education, School of Nursing, Calgary General Hospital, Calgary, Alta.

The book is designed to motivate the nursing student to a study of society through the introduction of concepts pertinent to our social systems. The authors are concerned with the need for the nurse to gain maximum insight into human relationships, a knowledge of which is vital to the promotion of health.

Part one serves as an orientation to basic sociological concepts. There is a danger with this type of textbook where basic material is presented in relation to a particular occupation or institution. The student tends to become interested in the material as it relates to a particular field, the result being a superficial approach and a narrow outlook. The authors have tried to prevent this by illustrating the basic concepts with examples drawn from various areas of society and by keeping references to nursing and hospitals to a minimum. An exception is found in chapter three where about a third of the illustrations refer to nursing groups.

The introductory chapter might rouse the ire of teachers who feel that nursing students should be allowed to determine for themselves why a study of sociology is important to nurses. The "why study this" approach is similar to that in countless other books. The study of culture is very brief. The material is presented concisely and clearly. The authors encourage and promote supplementary study through the inclusion of topics for investigation and interpretation and a bibliography at the end of each chapter.

The material is well-organized in that relationships are demonstrated by arranging that the study of personality development is followed by a discussion of changes in society that are contingent on the types of people in our society. The subject of communications is related to certain 20th century problems. The topic of population is made vital by reference to current situations such as school shortages, need for nurses, youth potentials and aging. The institution, the family, and the implications of community organization are reviewed in detail. The following areas of sociological study are reviewed very briefly: sociology as a science; relationship between psychology and sociology in the understanding of behavior; most of the social institutions.

Part two is concerned with the application of sociology to nursing. The teacher is guided in how this application might be made in the various clinical courses and experiences. The development of man is traced from the newborn, to the young adult and the later years. The sociological implications of each phase of development as well as those associated with acute and chronic illness are concisely outlined. Supplemental data will be needed for a complete study in any of these areas.

This book will be most helpful in those nursing schools where it is only possible to give a short introductory course in sociology. Nursing teachers with limited preparation in sociology should find the guide for application of the scientific principles excellent.

T-Group Theory and Laboratory Method by L. Bradford *et al.* 498 pages. John Wiley & Sons, Inc., N.Y. 1964.
Reviewed by Dr. Hedley Dimock, Director, Centre for Human Relations and Community Studies, Sir George Williams University, Montreal.

Here, at last, is the first book reporting the 17-year growth of the National Training Laboratories and its unique invention, the T-group. The T-group has been the subject of numerous articles and half a dozen books but this is the first comprehensive and reasonably integrated description of its origin and development; its philosophy, learning goals and process; its relationship to other educational methods such as classroom teaching and psychotherapy.

A typical T-group is composed of about 15 members with a trainer (the professional staff person) who is not the group leader but helps the group to learn through its own experiences. The group has no structure or agenda. It has over-all goals which help participants develop more insight into their own behavior and greater ability to

accomplish the purposes of the group. The trainer does not establish any discussion procedures nor does he suggest projects or tasks. The group is left to set its own goals and to work out and implement plans in any way that it sees fit. As the group gropes for some kind of structure and tries to provide its own leadership, the trainer interprets group problems; highlights interactions; helps members to understand the dynamics of the group and the impact of their behavior upon others. Usually, the T-group is the major focus of a laboratory program that includes lectures on relevant theory designed to help participants understand the T-group process; organize their learning; plan for the application of new knowledge to the work situation; provide practice in skills of group leadership and organizational change. Laboratory programs are often conducted in out-of-town locations (such as the NTL site in Bethel, Maine) in order to have the undivided attention of participants. This facilitates the development of a "cultural island" type of trust and security. Such programs usually last from 3 to 20 days.

Nurses were among the first professional groups to participate in T-group training. In Canada, the Registered Nurses' Association of Ontario has sponsored an annual laboratory training program since 1957. This reviewer knows of similar programs in Quebec, Alberta and British Columbia. The Human Relations Institute at Fort Qu'Appelle, Saskatchewan is the oldest laboratory in Canada. It was started just one year after the National Training Laboratory at Bethel. Nurses have been frequent participants since its beginning. Thus, there are quite a few nurses across Canada who have experienced this type of training and are using its learnings to improve the professional practice of nursing and the education of nurses.

For all of those who have had T-group training this will be a meaningful and helpful book. It may be useful in giving greater meaning to their experience. It may also serve as a stimulant to nursing educators who are anxious to consider new methods of education or who are interested in finding out more about this method of learning. The text will be of limited interest to the majority of nurses since it is most suited to professional trainers and educators, especially those already familiar with the T-group laboratory method.

Textbook of Medical-Surgical Nursing by Lillian S. Brunner, C.P. Emerson, Jr., L. K. Ferguson and Doris S. Suddarth. 1198 pages. J. B. Lippincott Co., Montreal. 1964.

This text stems from the fusion of two well-known nursing texts published by J. B. Lippincott Company, "Essentials of Medicine" and "Surgical Nursing." The material has been revised, up-dated and carefully selected to provide a comprehensive presentation for the nursing student.

Part One, concerned with "Fundamentals of Medical and Surgical Nursing," includes chapters relating to the preventive aspects of disease, therapeutic and supportive measures, the patient with a surgical problem, etc. *Part Two* concerns the care of patients with specific medical and surgical problems. *Part Three* consists of one chapter relating to emergency and disaster nursing.

The chapters describing the care of the patient in the operating room and O.R. nursing are particularly noteworthy. Altogether, 42 pages are devoted to this material which includes more than 35 excellent charts and diagrams.

Although a separate chapter is allotted to the subject of rehabilitation, specific information for the various diseases and injuries is provided throughout the text.

In *Part Two,* a bibliography is provided at the end of each chapter for additional reading; "Clinical situations" are included for self-testing; a list of pamphlets, booklets and brochures is given as possible "patient-teaching aids and information."

This is a very comprehensive, well-written text which will, no doubt, be greeted with enthusiasm by instructors and students alike. It would also be a very useful reference book for the registered professional nurse.

Bailey and Love's Surgery for Nurses by McNeill Love M.S., F.R.C.S. and Allan Clain, M.B., F.R.C.S. 533 pages. H. K. Lewis & Co. London. Ed. 9. 1964.

Reviewed by Miss Mavis Chittick, Surgical Instructor, School of Nursing, Calgary General Hospital, Calgary, Alta.

The intent is to provide the nurse with a modern and comprehensive account of surgical principles. This objective appears to have been met in a simple and concise manner. Nursing is not stressed but many suggestions are made towards improvement of nursing care. There is seldom any mention made of the patient's emotional problems and his need for supportive care when undergoing surgery.

The chapters added to this edition on

fluid balance, radiological investigation, surgery in the tropics, plastic surgery and surgery at the extremes of age are very helpful although brief. It is unusual in a book of this type to have so much pediatric surgery, plastic surgery and relatively rare or minor surgery incorporated.

The general material on bacteriology, inflammation and tumors is clear, concise and complete. Burns are discussed, along with decubitus ulcers and surgical shock, in the chapter on inflammation and wounds. The chapter on fluid balance discusses methods of choice in their administration. It is unfortunate that references to administration of fluids rectally or subcutaneously after surgery were not deleted from other sections of the text, as these methods are rarely used.

Although somewhat confusing at first, the frequent references to the many excellent illustrations and the system of referral to other sections of the book has helped to eliminate needless repetition and to keep the book within a reasonable size. The very concise style of presentation would be helpful to most student nurses since important points are emphasized but more detail would be helpful concerning some of the less common conditions. All aspects of abdominal surgery and most common surgical conditions are covered quite adequately. Special areas of surgery, such as urology, neurosurgery, gynecology, orthopedics and otolaryngology are included but, in some sections, more detail would be appreciated.

This book would be very useful for the student nurse or the graduate nurse working in a small general hospital. It does not appear to have enough detail to make it a helpful reference for the teacher in surgical nursing.

Sex and Sex Education by Warren R. Johnson. 205 pages. Lea and Febiger, Philadelphia, 1963.

Reviewed by Miss Jean Cummins, Calgary General Hospital, Calgary, Alberta.

As the title indicates, the author of this book is concerned with perspectives and problems related to human sex and sex education in our society. He is merely reporting on the situation that exists and, consequently, attempts to identify the factors that have contributed and are contributing to the present situation.

The book deals with problems that confront boys and girls as they mature from childhood to adulthood. It describes the prevailing attitudes and the sex behavior of adults in our country and other countries of the world. The author feels that ours is a "sex-centric" society and that we are greatly preoccupied with the fulfilment of sex desires in the sex act.

There are a number of topics that have been omitted in this book. There is no mention of the tremendous influence of television, radio, movies and literature on our attitudes. Neither is there any comment on the contribution of alcoholic beverages, accessibility of contraceptives, boredom because of lack of satisfying activity, etc., to the lowering of our moral standards and sense of values. These are areas that must be included if one is identifying the factors that contribute to the present situation.

This book could be of some value to teachers who are concerned with a sex education program. It would supply background information in relation to the present situation and identify some of the problems although it is not concerned with offering solutions to these problems.

Microbiology for Nurses by M. Frobisher, Sc. D., L. Sommermeyer, R.N., Ed. M. and E. Blaustein, M.P.H., Ph.D. 554 pages. W. B. Saunders Co., Phila. Ed. 11. 1964.

Numerous chapters in this eleventh edition have been completely rewritten while others have undergone extensive revision. Students and instructors alike should be pleased at the conciseness evidenced in this text and the attractive, easy-to-read format displayed throughout. Many excellent diagrams, photographs and charts are used.

This continues to be a useful text for the student nurse. It would also be suitable as a reference text in the school of nursing library.

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Registered Nurses for new 30-bed General Hospital. Salary and policies of the AARN. New residence for $35/m. Apply: Matron-Administrator, General Hospital, Bashaw, Alberta. 1-4-1

Registered nurses for a busy 51-bed active treatment hospital, situated in east central Alberta. Salary range from $340-$385 commensurate with experience. Sick Leave and pension benefits available, 40-hour work week, 21 days annual vacation plus statutory holidays, full maintenance in new nurses' residence for $30/m. For further information, apply to: Miss Margaret MacIntosh, Director of Nursing, Municipal Hospital, **ELK POINT,** Alberta. 1-34-1

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General Duty Registered Nurses. Salary schedules as per AARN. Experience recognized. Yearly increments and also a bonus at completion of 12 months' continuous service. A.B.C., M.S.I. and pension plan available. Phone collect to 116 Breton or apply: Administrator, Breton Hospital, Breton, Alberta. 1-12-1

General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $315-$360 for Alberta registered; $305-$350 for non-Alberta registered. New separate residence, excellent personnel policies and working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

General Duty Nurses. Starting salary: $315 per mo., 40-hr. work wk. Room, board & laundry available, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

General Duty Nurses (2) for modern 25-bed hospital on Highway No. 12. Salary range $340 to $385. New staff residence. Full maintenance $35, personnel policies include Blue Cross, M.S.I. and pension plans. 21 days' vacation per year, plus statutory holidays. Apply to the: Director of Nurses, Municipal Hospital, Coronation, Alberta. 1-25-1

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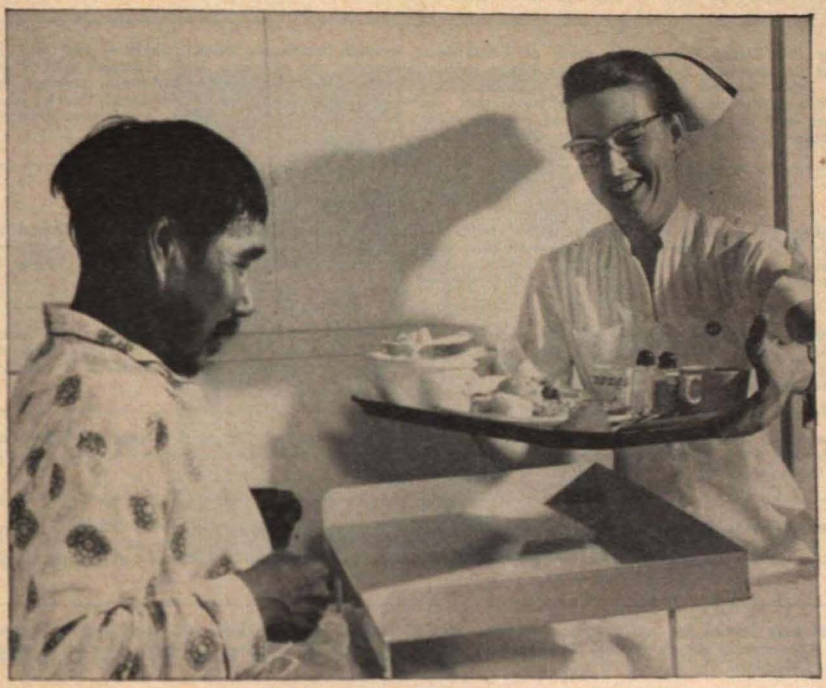

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Information on these and other positions is available from Medical Services Directorate, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

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NURSES fully qualified for 30-bed active treatment hospital. New hospital building and recently renoveted nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, General Hospital, Bassano, Alberta. 1-5-1

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Operating Room Head Nurse (Experienced) with postgraduate course for modern accredited 82-bed hospital. Salary: $381-$460 according to experience plus RNABC allowance for postgraduate course. Accommodation available, 10 statutory holidays, 4-wk. vacation, superannuation and medical plan coverage. Apply: Director of Nursing, General Hospital, Kitimat, British Columbia. 2-36-1A

Registered Nurses (2) Certified Nursing Aide (1) for 43-bed hospital. RNABC policies in effect. Salary B.C. registered nurse $340-$413; salary non B.C. registered $325. Room and board $50. Swimming, skating, curling, skiing, bowling, golfing and fishing. Apply: Director of Nursing Services, Memorial Hospital, Fernie, British Columbia. 2-22-1

Registered or Graduate General Duty Nurses for active 25-bed hospital. Salary B.C. registered $320 to start; unregistered $305. RNABC personnel policies in effect, nurses' residence available. Apply: Administrator, Lady Minto Hospital, Ashcroft, British Columbia. 2-4-1

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General Duty Nurses for new 30-bed hospital located in excellent recreational area. Salary and personnel policies in accordance with RNABC. Comfortable Nurses' home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia. 2-27-2

General Duty Nurses for fully accredited 113-bed hospital (82 beds in use) in N.W. B.C. Excellent fishing, skiing, skating, curling and bowling. Hot springs swimming within 20 minutes. 1964 salaries B.C. Registered $347 - $419. Non-Registered $332. Room and board $50/month. 10 statutory holidays, 11½ days sick leave, 4 weeks vacation. Superannuation and Medical Plan coverage. Apply: Director of Nursing, Kitimat General Hospital, Kitimat, British Columbia. 2-36-1

General Duty, Operating Room and Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $332-$404. Credit for past experience and postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. 2-73-13

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Operating Room, Obs. and General Duty Nurses for modern 450-bed hospital with a school of nursing. RNABC policies in effect. Salary $332/m. Credit for past experience and postgraduate training. 40-hr. wk., 10 statutory holidays, annual increments, cumulative sick leave, pension plan, 28-day annual vacation. B.C. registration required. For particulars write to: Director of Nursing Service, St. Joseph's Hospital, Victoria, Vancouver Island, British Columbia. 2-76-5

DO IT NOW! WHY WAIT FOR SPRING FOR THAT CHANGE? Graduate Nurses will be needed to increase the staff of the new 81-bed acute General Hospital, 30 miles from Vancouver, B.C. Applications will be received now for the opening in January, 1965 of the new Langley Memorial Hospital. Apply to: The Director of Nursing, Murrayville, British Columbia. 2-44-1

MANITOBA

Registered Nurses (2) for 16-18 bed hospital. Starting salary now $320, Jan. 1/65 $340/m., 50% of past experience allowed in determining salary. Good personnel policies, full maintenance $50/m. For further information write or telephone 78 (Mr.) M. McTaggart, Administrator, Memorial Hospital, Crystal City, Manitoba. 3-16-1

Registered and Practical Nurses (immediately) for 18-bed hospital at Vita, Man., 70-mi. from Winnipeg. Starting salary, R.N. $330 - L.P.N. $225, with allowance for experience. Daily bus service. 40-hr. wk., full maintenance available for $50/m. Apply to: Matron, District Hospital, Vita, Manitoba. 3-68-1

Registered General Duty Nurses (2) immediately, for fully modern 20-bed hospital. Salary $330/m, 40-hr. wk., increments of $5.00 every six months for eight increments. Full maintenance available at the hospital for $45/m. For further information and application forms apply to: Mrs. Olive C. Campbell, Matron, Hunter Memorial Hospital, Teulon, Manitoba. 3-63-1

General Duty Registered Nurses for 34-bed hospital. Salary $350-$410. 40-hr. wk. equivalent. Good personnel policies. For particulars contact: Director of Nurses, District Hospital, Souris, Manitoba. 3-58-1

General Duty Graduates (2) to fill vacancies in medical and surgical wards in a modern 70-bed hospital. Salary commensurate with experience. Good personnel policies. Bilingual community situated near Riding Mountain and the lakes. For more information please write to: Sister Superior, Ste-Rose General Hospital, Ste. Rose, Manitoba. 3-54-1

NOVA SCOTIA

Registered Nurses for 21-bed hospital in pleasant community — Eastern Shore of Nova Scotia. Apply: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia. 6-32-1

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply: Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia. 6-21-1

ONTARIO

Registered Nurses for modern 166-bed General Hospital. Interesting general duty positions open in all areas. Starting salary (1964): $330/m., 37½-hr. work wk. Congenial atmosphere, excellent fringe benefits and personnel policies. Limited residence accommodation available. For further particulars write: Director of Nursing, Memorial Hospital, Bowmanville, Ontario. 7-14-1

Registered Nurses for new 65-bed hospital. Resort area. Salary range: $315/m. Up-to-date personnel policies. Apply: Director of Nurses, South Muskoka Memorial Hospital, Bracebridge, Ontario. 7-15-1

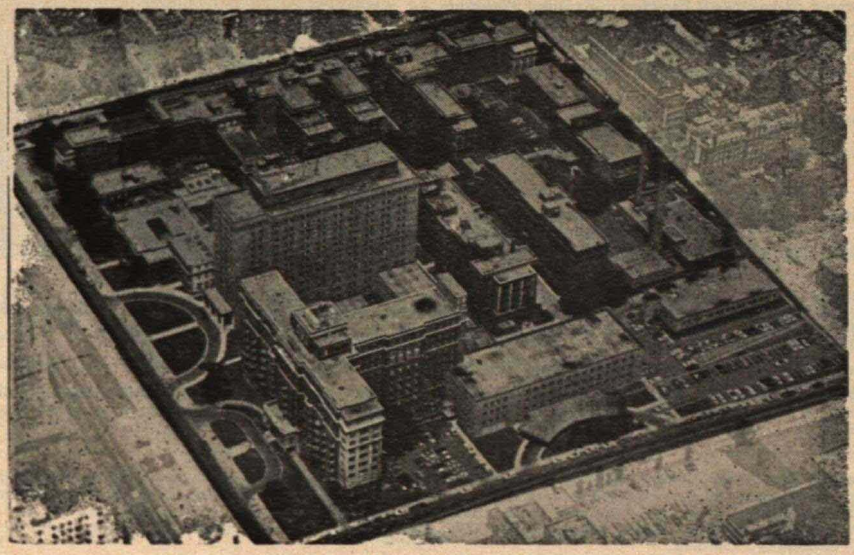
Registered Nurses for Surgical, Medical, Pediatric, Obstetrical Departments and Operating Room, required by 100-bed General Hospital, situated in Northern Ontario. Starting salary $360, annual increments, good personnel policies, including 40 hours per week. O.H.A. pension plan and group life insurance, O.H.S.C. and P.S.I. plans in effect. Accommodation available in residence if desired. For further particulars apply to: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses for 34-bed hospital, min. salary $350/m. — max. of $450 in five years, 3-wk. vacation with pay, sick leave after 6-mo. service. **All Staff** — 5 day 40-hr. wk., 9 statutory holidays, pension plan and other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario Pop. 3,500. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number, etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone 826-3251. 7-74-1A

Registered Nurses for 25-bed hospital. Minimum salary: $350 with allowance for experience. Registered Nursing Assistants, minimum salary: $250 with allowance for experience. Excellent fringe benefits. Board and room available in residence: $45/m. Apply to: Mrs. G. Gordon, Superintendent, Nipigon District Memorial Hospital, 98 Churchill St., Nipigon, Ontario. 7-87-1

TORONTO GENERAL HOSPITAL



NURSING OPPORTUNITIES

for

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS

Planned Orientation Programme — Inservice Educational Programmes. Opportunity to gain additional knowledge in specialized fields of nursing. Excellent personnel policies. Salaries commensurate with prevailing current salaries in Metropolitan Toronto.

For information or application write to:

DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL
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Requires for New Psychiatric Unit

SUPERVISOR: Postgraduate training and experience in Psychiatry essential. Diploma Course in Teaching and Supervision an asset.

REGISTERED NURSES: With postgraduate training and experience in Psychiatry, for general staff duty.

Salary for both positions commensurate with education and experience. Excellent personnel policies.

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REGISTERED NURSES REQUIRED

FOR GENERAL DUTY IN MODERN 18-BED PRIVATE HOSPITAL IN IRON MINING TOWN, 140 miles north of Sault Ste. Marie, Ontario. SALARY RANGE $330 MINIMUM TO $377 MAXIMUM. Allowance for experience. Board and room available at $20 per month. Transportation allowance up to $50 after 6 months.

Apply:

SUPERINTENDENT OF NURSES, LADY DUNN HOSPITAL, WAWA, ONTARIO

Registered Nurses for 60-bed hospital. Accommodation available in nurses' residence, pleasant working conditions and up-to-date personnel policies. Contact: Director of Nursing Services, Memorial Hospital, St. Marys, Ontario. 7-112-1

Registered Nurses and Registered Nursing Assistants for well-equipped 75-bed hospital in progressive town of 6,500, situated midway between Winnipeg and the Canadian Lakehead. Basic wage Reg.N., $330 and Reg.N.Ass'ts, $230/m. with single room accommodation available in modern nurses' residence. Excellent personnel policies. For further information, please phone or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

Registered Nurses, Certified Nursing Assistants (IMMEDIATELY) for 40-bed hospital in pleasant town of 5,000. 42-hr. wk. with good rotation shifts, providing long weekends every 4 wks. Good salaries and personnel policies. For further details and application, apply: Administrator, General Hospital, Espanola, Ontario. 7-41-1

Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $350 and $240 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries $335 and $225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

Registered Nursing Assistants for well-equipped active 35-bed General Hospital. Good personnel policies. Hospital is located 35 miles north-west of Toronto. For further information please phone or write: Superintendent, The Cottage Hospital (Uxbridge), Uxbridge, Ontario. 7-135-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only $45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range $350 - $375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered Nurses for General Duty in all departments including Premature and New-born Nursery, Isolation, Emergency, Recovery Room, and Intensive Care Unit. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty and Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $335 per mo.**, with annual merit increments, plus **annual bonus plan**, 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury**, Ontario. 7-127-4

Registered Nurses for General Duty in 100-bed hospital, located 30-mi. from Ottawa, are urgently required. Good personnel policies, accommodation available in new staff residence. Apply: Director of Nursing, District Memorial Hospital, Winchester, Ontario. 7-144-1

Registered Nurses for General Staff in active 300-bed hospital. Apply: Director of Nursing, General Hospital of Port Arthur, Port Arthur, Ontario. 7-106-1

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

General Duty Nurses for 66-bed General Hospital. Starting salary: $335/m. Excellent personnel policies. Pension plan, life insurance, etc., residence accommodation. Only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

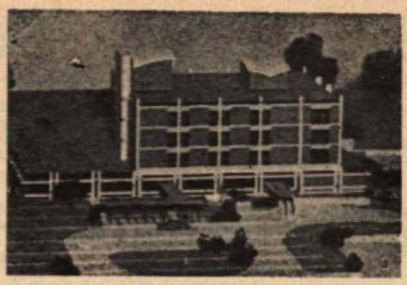
General Duty Nurses for modern 100-bed hospital. Registered Nurses $325-$355/m, Graduates $285-$325/m, 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital. Southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $325/m basic salary. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses for 325-bed fully accredited General Hospital located in downtown area of city. Planned orientation program. Progressive personnel policies. Apply to: The Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment, 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Graduate Nurses and Certified Nursing Assistants (Immediately) for progressive rapidly expanding hospital in central Toronto. Salary commensurate with experience and excellent employee benefits. For specific information please reply in confidence to: The Director of Nursing, The Wellesley Hospital, 160 Wellesley Street East, Toronto 5, Ontario. 7-133-49



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OPENING: OCTOBER 1964

VACANCIES for O.R. Supervisor and O.R. Nurses. General Duty R.N.'s and Registered Nursing Assistants (Union Agreement for Registered Nursing Assistants) in Medicine and Surgery, O.R., O.B.S., Pediatrics. Salaries commensurate with prevailing salaries in Metro Toronto. Consideration for experience and education. Overseas nurses welcome. Personnel recognition and excellent fringe benefits. Professional developments fostered.

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Apply to:

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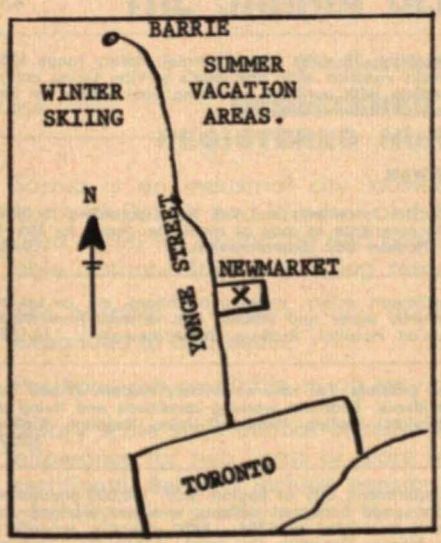
AJAX AND PICKERING GENERAL HOSPITAL
Ajax, Ontario

YORK COUNTY HOSPITAL



ONE HOUR FROM DOWNTOWN TORONTO

260-bed Hospital with new facilities including:

INTENSIVE CARE UNIT
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PSYCHIATRIC UNIT

REGISTERED NURSES: $335-$400 per month

REGISTERED NURSING ASSISTANTS: $230-$265 per month

LIBERAL PERSONNEL BENEFITS INCLUDE:

Pension Plan, Group Life Insurance,
Medical and Hospital Insurance,
Residence accommodation available

Please write for further details concerning employment opportunities to:

DIRECTOR OF NURSING, YORK COUNTY HOSPITAL
Newmarket, Ontario

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

Operating Room Nurses (2) and General Duty Nurses for this 150-bed hospital. Salary scales as applicable in Ontario. Recognition for experience. All conventional benefits available. Apply giving details of training and experience to: The Director of Nursing, The Cottage Hospital, Pembroke, Ontario. 7-98-1

PUBLIC HEALTH NURSES (qualified) generalized program. Salary RNAO recommendations, $4,200-$5,250, transportation allowance $65 per working month, one (1) month vacation, O.M.E.R.S. pension plan, O.H.S.C. and Windsor Medical Services available, uniform allowance. Apply to: Dr. Ian Cunningham, Director, Kent County Health Unit, 21 Seventh Street, Chatham, Ontario. 7-24-4

PUBLIC HEALTH NURSES (Qualified) for stormont, Dundas and Glengarry Health Unit located in the St. Lawrence Seaway Valley area. Generalized program. Good personnel policies and working conditions. Salary to be assigned, on the basis of experience. Apply to: Dr. John A. Thomson, Medical Officer of Health, Box 1058, Cornwall, Ontario. 7-34-5

PUBLIC HEALTH NURSE (QUALIFIED). Salary range $4,200 - $5,200; annual increment $210. Required in a generalized program in the City of Oshawa. Transportation provided and usual employee benefits. Apply to: D. Fleming, Personnel Officer, Civic Administration Bldg., OSHAWA, Ontario. 7-92-2

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 150-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda. 13-1-1B

QUEBEC

Assistant Head Nurses and Certified Nursing Assistants for 60-bed children's orthopedic hospital. Excellent personnel policies. Apply: Miss Flora M. Lamont, Reg.N., Administrator, Shriners Hospital for Crippled Children, 1529 Cedar Avenue, Montreal 25, Quebec. 9-47-42

Registered Nurses for 30-bed General Hospital, 50 mi. from Centre of Montreal. Excellent bus service. Starting salary: $325/m. Salary increases as recommended by ANPQ. 40-hr. wk. Annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Que. 9-29-1

Operating Room Nurse, (experienced) to act as senior in operating room of 33-bed hospital with very active general surgical service. Starting salary $425 and up, depending on previous experience. Excellent living conditions and fringe benefits. Nurse holding this position will be eligible for position of operating room supervisor in new 75-bed hospital, to be completed in one and one-half to two years. Apply in writing to: Dr. D. S. Thurber, Medical Director, **Boisvert Memorial Hospital, Baie Comeau, Quebec,** stating qualifications and experience, and giving telephone number. 9-7-1

Operating Room Nurses for 56-bed accredited General Hospital, 38 miles from Montreal. Salary range $355-$385/m. Excellent working conditions, 5 day week, 4 weeks vacation after one year's service. Living accommodation available in modern motel type residence complete with out-door swimming pool. Apply to: Mrs. M. Fearn, Director of Nursing, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1B

SASKATCHEWAN

Matron for new 14-bed hospital. Salary open for negotiation. Increments and sick leave according to SRNA schedule. Accommodation available in residence. Duties to commence as soon as available. Apply to: Mrs. D. Spark, Secretary-Manager, Hudson Bay Union Hospital, Hudson Bay, Saskatchewan. 10-46-1

Matron for busy 25-bed hospital situated in S.E. Saskatchewan, salary, working conditions, etc. as set out by the SRNA. Nurses' residence, town fully modern, sewer, water and natural gas. 40-min. from Moose Mountain Provincial Park. Apply: Secretary-Manager, Union Hospital, Redvers, Saskatchewan. 10-108-1

Registered Nurses (2) — Duties to commence as soon as possible. For new completely modern 27-bed hospital. Initial salary $325/m. 40-hr. wk., new modern residence. Excellent working conditions and living accommodation. Apply to: Superintendent of Nursing Services, Kipling Memorial Union Hospital, Kipling, Saskatchewan. 10-59-1

Public Health Nurses (required immediately) for Health Department, City of Regina, with 130,000 population, approximately 10 sq. miles in size. Generalized program, good personnel policies, excellent working conditions. Salary range $344 - $437/m, plus car allowance, increasing to $354 - $450 effective January 1, 1965. Must possess a Diploma in Public Health Nursing from a Canadian University. Applications and enquiries should be directed to the PERSONNEL DEPARTMENT, CITY HALL, REGINA, SASKATCHEWAN. 10-109-8

U.S.A.

Registered Nurses for General Duty for 21-bed hospital in scenic Southeastern Alaska. Apply: General Hospital, Petersburg, Alaska 99833. 15-2-4

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary for nurses registered in the Province of Ontario $335 monthly with annual increment $10 monthly to $385.

Salary until registration is established — $305 monthly.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE SARNIA GENERAL HOSPITAL

Offers excellent opportunities for

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS

Sarnia is an industrial city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

The hospital is modern, fully approved (JCAH), and has recently been expanded to 350 beds.

Positions are available in all services.

Salary scale with annual increments to the maximum. Additional salary allowance for two years or more acceptable experience or postgraduate certificate. Benefits include pension plan, 40-hour week, regular rotation of shifts with premium pay for evenings and nights.

Apply:

PERSONNEL DIRECTOR,
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

OPERATING ROOM TECHNICIANS for new surgical suite in expanding 245-bed JCAH accredited hospital in So. Calif. resort city. Attractive personnel policies. Apply: Director of Nursing Service, Cottage Hospital, 320 W. Pueblo Street, Santa Barbara, California. 15-5-39B

Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula, yet only 20-min. from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect. OXford 7-4061 or write: Director of Personnel, Penninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $395 with automatic increase to $455 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses, all shifts, for new 60-bed Children's Hospital of Orange County and new 290-bed St. Joseph Hospital operated by Sisters of St. Joseph of Orange, California. California license required. Excellent salary and benefits. Write: Personnel Director, St. Joseph Hospital, Orange, California. 15-5-56

Registered Nurses for private 278-bed hospital for men, women and children. Staff Nurse salaries from $400 - $465, differentials for evenings and nights. Opportunities in all clinical areas. Holidays, vacations, sick leave, life insurance and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — All services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation, San Francisco 15, California. 15-5-57

REGISTERED NURSES — General Duty for 84-bed JCAH hospital 1½ hours from San Francisco, 2 hours from Lake Tahoe. Starting salary $420/m. with differentials. Apply: Director of Nurses, Memorial Hospital, Woodland, California. 15-5-49B

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

(a) **Operating Room Nurses** (experienced); basic salary $385 with good financial reimbursement for call. (b) **Obs. Nurses** $385 basic salary with $20 differential for 3-11 or 11-7 shifts. (c) **General Duty Nurses** $375 basic salary; $20 differential for 3-11 or 11-7 shifts. Apply: Director of Nurses, General Hospital, Eureka, California. 15-5-14

OPERATING ROOM NURSES for new surgical suite in expanding 245-bed JCAH accredited hospital in So. Calif. resort city. Attractive personnel policies. Housing allowance for first month. Current valid Calif. license required. Apply: Director of Nursing Service, Cottage Hospital, 320 W. Pueblo Street, Santa Barbara, California. 15-5-39A

Staff Nurses for 300-bed County Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Staff Nurses for 245-bed JCAH accredited hospital in southern California resort city. Starting salary $395 - plus $22.50 shift differential. Housing allowance for first month. Current valid Calif. licence required. Apply: Director of Nursing Cottage Hospital, Santa Barbara, California. 15-5-39

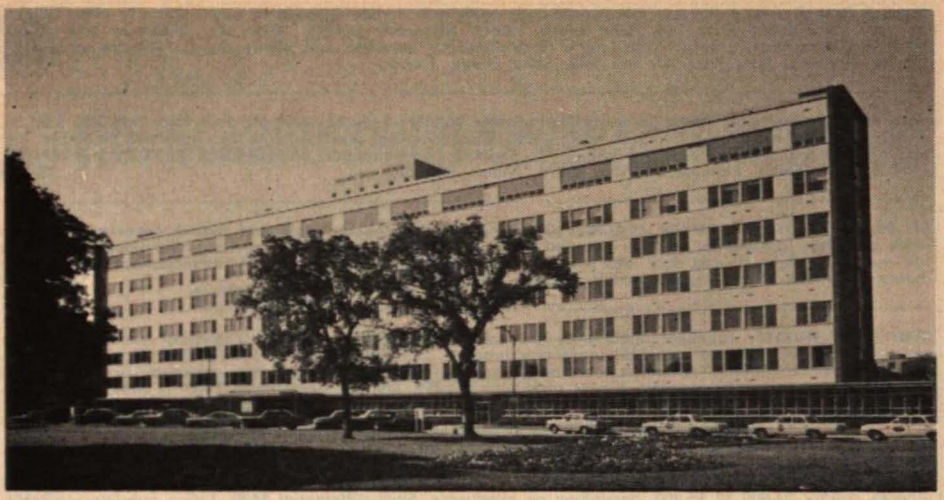
STAFF NURSES for 100-bed JCAH hospital located in the San Joaquin Valley. Salary $415, differential for evenings and nights $10. Frequent promotions to head and supervising positions. Liberal fringe benefits, modern nurses' residence. Call or write, Director of Nurses, Tulare County Hospital, Tulare, California. 15-5-44

Staff Duty positions (Nurses) in private 403-bed hospital. Liberal personnel policies and salary. Substantial differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-3B

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for 72-bed hospital. Salary $425/m, fringe benefits. College town, mountainous portion of Colorado. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

REGISTERED NURSES: for 75-bed air conditioned hospital, growing community. Starting salary $330-$365/m, fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization. 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1



THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

Applications are invited for the position of:

DIRECTOR OF NURSING

OSHAWA GENERAL HOSPITAL

This position will become vacant upon the retirement of our present Director of Nursing. Oshawa General Hospital is a 540-bed Active Treatment hospital which includes medical, surgical, chronic, paediatric and obstetrical units. Our School of Nursing has 120 students.

Expansion plans are presently being studied for all areas of the Hospital. This is a challenging position and applicants with experience in Nursing Service and Nursing Education, with a Baccalaureate degree will be given preference. Starting date will be within the next year.

Please address all enquiries to:

W. A. Holland, Administrator,
OSHAWA GENERAL HOSPITAL,
24 Alma Street, Oshawa, Ontario.

General Duty Nurses — Present hospital 55-beds, with new 75-bed hospital to open April, 1, 1965. Located on Lake Okeechobee near west Palm Beach. Liberal personnel policies, 40-hr. wk., bonus at end of first year. Minimum starting salary $380, with differential for evenings and nights. Apply: Director of Nursing Service Memorial Hospital, P.O. Box 928, Belle Glade, Florida. 15-10-3

Help Wanted! Registered Nurse in sunny Florida near West Palm Beach. Starting salary for R.N.'s is $375/m. 40-hr. wk. Good working conditions. New 50-bed hospital under construction. Living quarters available. S.E. end of Lake Okeechobee. Write or call: J. C. Simonds, Administrator, **EVERGLADES MEMORIAL HOSPITAL**, 1749 E. Main Street, Pahokee, Florida. 33476. Phone: 924-5502. 15-10-4

ST. FRANCIS HOSPITAL, MIAMI BEACH, FLORIDA. Positions open for Staff and special departments. $80 a week day shift; differential for evenings and nights. Good vacation policy, paid hospitalization, pension and life insurance plan. Private duty and short term per diem work $20 a day. Accommodations available in nurses' residence. Ocean bathing within walking distance. Must speak English. 15-10-2

REGISTERED NURSES: Excellent opportunity for advancement in atmosphere of medical excellence. Finely equipped, growing 200-bed suburban community hospital on Chicago's famed "North Shore" offers stimulating professional contacts within framework of personal attention. Completely air-conditioned, furnished cottages; two week paid vacation, liberal personnel policies. Starting salary from $410 to $430 days. Differential of $30 for nights or evenings. Contact: Donald L. Thompson, R.N., Director of Nursing, Highland Park Hospital, Highland Park, Illinois. 15-14-3

General Duty Staff Nurses for 215-bed General Hospital, 30-min. from New York City. All shifts, all services. Salary $4,800 to $5,200, depending on experience. Shift differential $540. Living quarters available. Apply: Director of Nursing, General Hospital, Yonkers, New York. 15-33-7A

Staff Nurses 380-bed hosp. new 120-med.-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med.-Surg. & occasionally O.B., Peds., & O.R., salaries $350 per mo. even., night or O.R. with call; annual increases up to $410; days $340 per mo. with increases up to $400 Rotation from day duty is required only when no person desiring permanent P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 5 yrs. — 3 wks., 10 yrs. — 4 wks. Active in-service program. Occasional vacancy hosp. owned appts. New Mexico licensure as professional nurse and U.S. citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Alburquerque, New Mexico. Phone 243-5611. 15-32-3

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetrics and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $410 with semi-annual increments. Extra for night and relief duty. 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodation in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $411/m. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomach Hospital, Portland, Oregon. 97201. 15-38-1

STAFF NURSES All Clinical Services. Starting salary $382 for day shift; $419 for evening and night shifts; opportunities for advancement. Personnel policies, sick leave, retirement plan, 3-wk. vacation and laundry of uniforms. Orientation and in-service programs. Housing available on Campus. Apply: Director, Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

Director of Nursing for small 38-bed General Hospital adjacent to resort area. Responsible for all nursing activities. Liberal salary and benefits. Supervisory experience required. Apply in writing to: Administrator, Copley Hospital Inc., Morrisville, Vermont. 15-46-4

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and

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KENORA, ONTARIO

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Mark envelope: Re: A.D.N.S.

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and
REGISTERED NURSING ASSISTANTS

for

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The Director of Nursing
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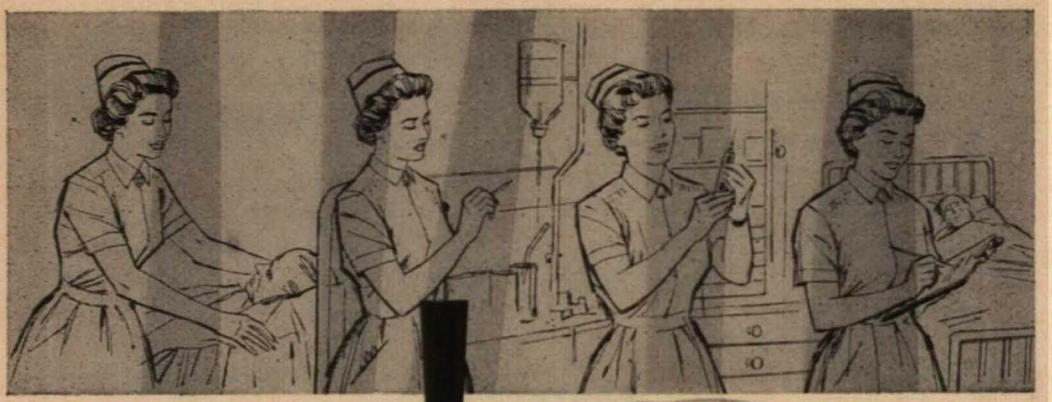

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